UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF MISSISSIPPI
WESTERN DIVISION

ANGELA ANDERSON, Personally,
and on behalf of the WRONGFUL
DEATH BENEFICIARIES of PRINCESS
ANDERSON, Deceased PLAINTIFF

VS. NO. 3:12-CV-92-MPM-SAA

MARSHALL COUNTY, MISSISSIPPI and
BAPTIST MEMORIAL HOSPITAL-DESOTO DEFENDANTS

**********

DEPOSITION OF THOMAS FOWLKES, M.D.

**********

TAKEN AT THE INSTANCE OF THE PLAINTIFF
IN THE LAW OFFICES OF CLAYTON O'DONNELL, PLLC
1300 ACCESS ROAD, SUITE 200, OXFORD, MISSISSIPPI
ON JANUARY 9, 2014, BEGINNING AT 9:00 A.M.

APPEARANCES NOTED HEREIN

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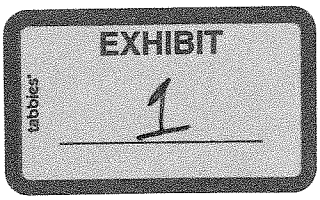




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THOMAS FOWLKES, M.D., after being duly sworn, testified as follows:

EXAMINATION

BY MR. CZAMANSKE:

Q. Would you please state your full name for the record.

A. Thomas Fowlkes.

Q. And I don't need your specific address, but generally where do you reside?

A. I live in Oxford, Mississippi.

Q. And, Dr. Fowlkes, have you ever given a deposition before like we're doing here today?

A. I have.

Q. I introduced myself just before we started, my name is Dan Czamanske. And I along with Danese Banks, we represent the family of Princess Anderson. Do you understand that?

A. I do.

Q. You understand that every question I ask and every answer you give is going to be taken down today?

A. I do.

Q. You understand that you're sworn in under oath to testify just the same as if you were sitting in a courtroom?

A. I do.
Q. If I ask you a question that you don't understand for some reason, tell me and I'll rephrase it for you. Okay?
A. Okay.
Q. If I ask you a question you think is unfair, please, tell me and I'll do my best to rephrase it, as well. Okay?
A. Okay.
Q. If you need to look at any document to give me your best answer on any question I ask, you're free to look at any document that you want. Do you understand that?
A. Yes.
Q. I was looking through your documents, and I want to go through this real quick just to see what we've got here. Let me go ahead and start with this. I'm going to identify some things. I'm not going to mark everything because some of these things we already have and they're filed in the case. The first thing you have, obviously, is a copy of your opinion dated November 22, 2013. Is that true?
A. That is correct.
Q. All right. The second thing we have is a copy of your curriculum vitae, which is two pages



long. And I've been provided a copy, but in case this is an updated one can I go ahead and mark this one?
A. Yes. I don't believe it's updated, but, yes.
Q. Okay. Well, I do see a difference, though, in the cases because the case list that I had only had two cases listed and this case list has six. Is this case list that's -- it's Page 3 of your CV. Is that an up-to-date case list in which you've offered expert opinions?
MR. O'DONNELL: I think the difference is the time frame.
A. It's up to date. It's the same that I submitted earlier.
Q. All right. So maybe this one goes back further, is that what it is?
MR. O'DONNELL: That's right.
Q. Okay. In any of the cases listed on your case list, have you testified that a medical provider, any medical provider, breached standard of care in your opinion in any of these six cases?
A. Yes.
Q. Which ones?
A. This case (Indicating).



Q. Tell me the name of it.
A. Hauss et al versus Wallace et al.
Q. What kind of case was that?
A. Medical malpractice.
Q. Who were you retained by?
A. The plaintiff.
Q. Who was the plaintiff's lawyer, do you remember?
A. A firm in Tupelo. Steve Corban was the --
MR. DAVIS: Mitchell Voge?
A. Yes. He went to work -- he quit in the middle of the case, and went to work for People's Bank as the corporate counsel, and turned it over to Charlie Merkel in Clarksdale. You might say Charlie Merkel was the -- I mean, that was the ultimate.
Q. Did it go to trial?
A. No.
Q. Did you give a deposition in that case?
A. Yes.
Q. Any other case that you have listed here where you testified that a medical provider breached the standard of care?
A. No.
Q. Do all six of those cases involve issues of medical malpractice?



A. No.
Q. Which of those cases involve issues of medical malpractice?
A. Only that one.
Q. The other five cases, did they involve issues of prisoners' rights or inmates' rights?
A. They involved issues regarding prisoners. I don't know that it was their rights.
Q. All right. Well, tell me -- you describe for me, if you can -- now, look, if the five cases that we're talking about, if they can't be categorized as a single type of case, that's fine. Describe for me if you would the type of cases that were involved.
A. We could start right here.
Q. Sure.
A. This was a case in which I did a competency evaluation for chancery court (Indicating).
Q. Tell me the name of it.
A. In re, Conservatorship, Curtis Mize.
Q. So you were retained by the court to examine a person and render an opinion as to their competency?
A. That's correct.
Q. What sort of issues were you looking at to

determine that person's competency?
A. Their mental function, their intellectual function, their ability to reason and to make financial decisions.
Q. Were you looking -- well, go ahead. What's the next one?
A. These two cases -- the State versus -- Mississippi versus White was a criminal case, in which case I was retained by, I actually don't recall whether it was the plaintiff or the defense, but it was a murder case in which the defendant was significantly impaired due to alcoholism and I testified about that. Essentially for her. I think I was actually called by the prosecutor, but I mean -- well, no, I was -- I can't recall. I was an expert witness for one or the other, but it was to testify about her -- about her mental state at the time of the crime.
Q. All right. And what sort of opinion did you -- did you testify in court?
A. I did.
Q. What opinion did you reach with regard to her mental state?
A. That she was -- well, it was that she was significantly impaired due to intoxication at the



time. And that subsequently, when I took care of her -- the reason I got involved in the case I took care of her in jail. She developed severe alcohol withdrawal and she was a severe alcoholic, and we ultimately had to care for her for a long period of time. She became -- she had organic brain syndrome as a result of her long term alcoholism, so she remained -- I don't know -- she did not remain incompetent because she was ultimately convicted in the case, but she had significant impairment in her mental function later on as a result of her chronic alcoholism.
Q. All right. And what was the next one?
A. This State of Mississippi versus Grose, Grose and Jordan. I was retained by the defense on a person whose name was not on there. This was a sexual abuse case in which one of the defendants had significant organic brain syndrome as a result of chronic drug use and chronic inhalation use -- inhalant use, huffing. And she -- the person I was retained for made a -- was not one of these people. She made a plea deal because she was -- her mental capacity. She was mentally retarded and had significant mental impairments due to her chronic drug use.



Q. So was your opinion with regard to the issue of mental impairment due to drug use?
A. And mental retardation.
Q. And I take it then you did not testify at trial because she apparently pleaded out?
A. No. I did testify at trial because she was a witness against co-defendants.
Q. Okay. What's the next one?
A. The one I told you about, the medical malpractice, Hauss versus Wallace.
Q. Yeah, let's skip that.
A. These other two, this was --
Q. Go ahead and say the name.
A. State versus -- Mississippi versus Dill. Was a criminal case in which a young man was on trial for vehicular manslaughter.
Q. What sort of opinions did you offer in that case?
A. I was an expert for the prosecution regarding the causation of the wreck and his level of impairment.
Q. So you would have testified based upon certain evidence what that individual's impairment was at the time of the accident?
A. Yes. In addition to that I was -- in



addition to that I testified as -- I was the medical examiner investigator that ruled on the cause of death as well in the case. So I testified about the cause of death and the causation of the accident.
Q. And the top one, State of Mississippi versus Joiner looks like?
A. I was called as an expert, but that was a criminal case, State of Mississippi versus Joiner, in which he was charged with vehicular manslaughter, or actually, something more than vehicular manslaughter. But it was a vehicle case, in which I testified about the injuries to the decedent and the cause of her death. That was the medical examiner investigator in that case.
Q. Now I notice that all these are trial testimony than as expert testimony list; is that right?
A. With the exception of the one here, which I gave only a deposition and did not testify at trial.
Q. Oh, in the one with Charlie Merkel?
A. That's right.
Q. So is this a complete list? Does this include all cases in which you've offered an expert opinion, all civil or criminal cases?
A. Yes. There is one -- there is a present

case which I have offered an opinion -- I have offered a report on another conservatorship, and I cannot even tell you the name of that case. I've offered the opinion to the attorney, but I've not heard -- about six months, and have heard nothing since.

Q. And does that have to do with the level of mental impairment of the individual?

A. Yes.

Q. So to make sure I understand the areas in which you've offered expert testimony according to your expert list and according to what you've told me today, you've offered opinions with regard to cause of death, right?

A. Yes.

Q. With regard to injury causation?

A. Yes.

Q. With regard to the standard of care?

A. Yes.

Q. And with regard to mental impairment, as well?

A. Yes.

Q. Okay. Have you offered previously in any case any expert opinions on the area of institutional liability with regard to the care and treatment of



inmates?

A. No.

Q. Okay. Have you offered any opinions -- strike that. I forgot to write this down, with regard to that Hauss case, did that involve an emergency room setting?

A. It involved an urgent care setting.

MR. CZAMANSKE: We're going to mark -- well, it's more than just the CV. It's the CV, case list, plus your opinion. We're going to mark that as Exhibit 1.

(Exhibit No. 1 was marked).

Q. You went to the University of Tennessee Medical School?

A. That is correct.

Q. You would have graduated in 1989?

A. That is correct.

Q. Did your residency at the University of Pittsburgh in emergency medicine?

A. That's correct.

Q. After your residency tell me about your work history.

A. I worked in Memphis for three years as an emergency physician. Moved to Oxford in 1996 and practiced as an emergency physician since that time.



Q. As far as your experience goes, it sounds like your experience is primarily in the area of emergency medicine. Is that a fair characterization?

A. It was that until three years ago when I have developed experience in addiction medicine as well -- four years ago, I'm sorry. Time marches on.

Q. So up through about 2010, somewhere -- I'm not going to hold you to an exact date -- but somewhere around in there, your primary professional focus would have been emergency medicine?

A. And correctional medicine.

Q. Tell me what you mean when you say correctional medicine.

A. I have been the medical director and the jail doctor, for lack of a better term, since approximately 1996 at the Lafayette County Detention Center.

Q. What type of facility is that? What type of inmates do they house?

A. Two types. It's a county jail, so much like any other county jail in Mississippi. In addition to that, we're the federal holding facility for the Northern District Court, Federal and Northern District Court, so we hold federal pre-trial detainees.



Q. And so you've been the medical director there since 1996 through the present?

A. That's right. Everyday.

Q. Was that an appointment? Did you apply? How did you get that position?

A. It's a contract with the -- I'm a contractor of the county.

Q. Is it an annual contract? Is it an every five year contract? How does that work?

A. It's a contract until terminated by either party, and it's been ongoing since '96.

Q. You've been working under the same contract since you started there?

A. That's right. Essentially, I am responsible for outpatient health care at the jail. So in other words, it's a contract where I am charged with being in charge of all the inmates' health care and I'm responsible for providing all outpatient health care.

Q. As part of your responsibilities, do you go to the jail and see or examine inmates?

A. Yeah, absolutely.

Q. Do you do that on -- do you have a routine like every certain day of the week or every couple of days of the week you go down there --

A. I'm responsible for the inmates 24/7. I have had a variety of different schedules over the course of my 15 years, but the short version is that I'm responsible for their care 24/7 and I go there on a daily or almost daily basis.

Q. And you currently work in the capacity as an emergency room physician?

A. I do.

Q. Where is that?

A. Well, I have -- I don't work in the emergency department, but I work as an emergency physician at the Lafayette County Detention Center, and I have my own urgent care walk-in clinic.

Q. What's the name of that?

A. Thomas Fowlkes Medical Clinic.

Q. Is that here in Oxford?

A. It is.

Q. How long have you had that?

A. Four years.

Q. And so let's go four years back. Let's go to 2010. Well, let me ask you this. When was the last time you worked in an emergency room, in a hospital?

A. 2007 or '8. 2008 I would say.

Q. Which hospital would that have been in?



A. The last -- the very last place that I worked would have been Tupelo, North Mississippi Medical Center.

Q. And I know -- you know, I know a lot of the emergency departments, they contract out for ER physicians, and a lot of physicians moonlight as ER physicians, do it on the side, as well. Tell me what your arrangement was with Northwest Mississippi -- North Mississippi Medical Center.

A. Contract physician for a contract management company.

Q. And from the time of the end of your residency when you came back here, through 2008 or thereabouts, did you work in an emergency room department continuously during that time?

A. Either in an emergency department or an urgent care, acute care -- there are other venues in which you can work other than a hospital based on emergency department. And for a number of years I worked in an urgent care in Tunica County. So I mean -- either urgent care or --

Q. What was the name of that?

A. Robinsonville Clinic, I think. I'm not sure. Tunica County Medical Clinics or Urgent Care. I'm not sure of the exact name of it. But an urgent



care that was operated by Tunica County up in Robinsonville.

Q. Well, tell me which hospitals other than North Mississippi Medical Center in Tupelo, which hospitals you've worked the ER departments at.

A. Baptist Hospital in Oxford. Baptist Hospital in Booneville. St. Joseph Hospital in Memphis. St. Francis Hospital in Memphis.

Q. And can you give me dates for those, rough dates -- I don't need the exact dates -- so I can get an idea of which time period we're talking about.

A. Ten years or more. Ten years or more ago.

Q. But can you give me dates like when you worked for St. Francis, when you worked for St. Joseph, when you worked for Baptist Oxford?

A. I have worked part-time at a number of hospitals over a number of years. I've also done other things along the way, as well. I mean, in other words, I have worked -- done this type of correctional medicine contract for 15 years. I've been doing that. For the last four years I've had my own urgent care. The last two years I've had my own drug alcohol treatment facility. I became board certified in addiction medicine in 2009 or '10. And I have a substance abuse treatment facility now.



Q. Where is that?

A. Etta, Mississippi.

Q. What's the name of that clinic?

A. The Oxford Centre.

Q. The Oxford Centre?

A. Uh-huh (Indicating yes). C-E-N-T-R-E.

Q. So let's say in the last year, 2013, give me an idea of how much of your time would have been spent working with the county inmates working with the addiction folks, working the urgent care -- I'm trying to get an idea of how your time is divided between these various groups.

A. Okay. Does it have to add up to 100 percent? Or can it add up to 150 percent? I spend about three quarters time -- no, I have an urgent care that I work at everyday. I also have a nurse practitioner, whom I supervise all day everyday. So right now I'm supervising a nurse practitioner at that urgent care. And I do that everyday. And so that is a full-time job, and I have -- at my walk-in clinic, my urgent care, primary care practice. I do that daily.

Q. Let me interrupt you and I apologize. But let's do this. Start with the job that takes up the most time and work me to the job that takes the least

time. In other words, rank them and then describe the time you spend with them.

A. Okay. They're all approximately equal. I have an urgent care, primary care walk-in clinic, that I run everyday, Monday through Friday, 8:00 to 5:00 and 8:00 to 1:00 on Saturdays. I don't deliver all the direct care. I have a nurse practitioner, as well. So when I'm occupied with something else, the nurse practitioner is there by himself and he calls me by phone as necessary. I see patients there some days. Some days more than others.

Q. Would you two, you and the nurse practitioner, be the only two people providing medical care there at that facility?

A. Yes, that's correct. In addition to that, I have the jail, and I have a full-time RN who now works with me 24/7, as well. In other words, she's there Monday through Friday 8:00 to 5:00. But in addition to that we both -- we share call in the evening time. In other words, if she gets a call and doesn't know what to do I take it. So I take call 24 hours a day for the jail.

Q. Is she physically located at the jail? Does she have an office there?

A. She does.



Q. Do you have an office at the jail?

A. I share the office with her.

Q. Which office do you spend more time in, talking about the last year now, the office there at the jail or the urgent care office? Or is it the same?

A. Well, I physically don't spend as much time at the jail. I'm mainly located at my office in Oxford, but now with electronic medical records I -- you know, in other words, I spend more time in my office at the urgent care than I do at the jail physically.

Q. All right. We haven't talked about the other third of your time, which as I understand it would go to the addiction facility?

A. That's right.

Q. The Oxford Centre?

A. That's right.

Q. You said that was in Etta?

A. Yes. That is 15 miles from here. That's where the inpatient facility is, and in addition to that I have an outpatient office center in Oxford, as well. But there's detox -- we have comprehensive level of services. We have detox services, residential treatment, and outpatient.



Q. Do you have somebody that's physically there at the Etta office?

A. We have a full-time psychiatrist that works with me.

Q. All right. And he or she would be located at the Etta office?

A. That's right.

Q. They would be there all day?

A. Yes, that's right.

Q. And so compared to the jail, do you spend more time at your office in the jail or more time at your office in Etta?

A. I spend more time in my office at my clinic doing work on all three of them, though.

Q. I understand.

A. And I'm a business owner, as well. I own that business. So some of my time is not direct patient care, but operating --

Q. Right. And I'm not trying to discount that, but my question -- I'm trying to get an idea of where you're sitting most days. And --

A. It's in my urgent care clinic.

Q. Wait till I'm done with my question. I know you sit there mostly, but I'm trying to compare -- I know you've got an office and sometimes you're



at the jail. And I'm sure -- I know you have an office in Etta, and sometimes I'm sure you're at that office. Compared to the jail, do you spend more time in Etta or more time at the jail? Physically spend time?

A. Etta.

Q. Okay. Do you have any psychiatric training?

A. I have training on mental illness and substance abuse as part of my emergency medical training. It's a fairly big portion of emergency medicine training.

Q. Would that be considered psychiatric training?

A. It would be considered training to deal with psychiatric patients and substance abuse patients. Absolutely. It's a core competence of emergency medicine.

Q. I understand that. You would agree with me that there is a specialty that would be called psychiatry?

A. Absolutely. And I'm not board certified in psychiatry.

Q. I understand that. You're not board certified, but do you have a degree in psychiatry?

A. I do not have a degree in psychiatry.
Q. Have you taken, you know, higher education courses specifically on the topic of psychiatry?
A. Yes.
Q. Where would you have taken those and tell me what areas those would involve.
A. In my emergency medicine residency, the training to deal with psychiatric patients and substance abuse patients. So, for instance, there's a rotation at the Western PA Psych Hospital. That's one of my rotations at the Western Pennsylvania Psychiatric Institute.
Q. All right.
A. And there's other -- I mean, in the emergency department there's another rotation that I did specifically at the psychiatric emergency department at The Med in Memphis.
Q. Your CV says you're a certified medical review officer for drug and alcohol testing. Tell me what that means.
A. In order to review drug tests for federal programs through the Department of Transportation you have to be certified as a medical review officer. In other words, you have to take a course and pass a test to interpret and certify drug testing under the



Department of Transportation programs, so drunk drivers -- those kinds of people.
Q. So if -- I know sometimes if they're in an accident they drug test the truck driver?
A. That's right.
Q. And maybe that's pursuant to DOT procedures?
A. It is.
Q. And you would be certified to interpret those drug tests?
A. That's correct.
Q. Is that the only thing that that certification is used for?
A. That's the only thing that you are required to be certified in. Now, obviously, there was more training -- the reason I took it was not so I could be certified to do DOT, but so I could be -- so I could have more knowledge from a clinical standpoint about drug testing and drug testing procedures and results, and how to interpret -- I use drug tests on a daily basis clinically.
Q. All right. The urgent care practice that you have, let me ask you about that just for a moment. I know, for example, here in our area I know The Med is a Level I trauma center. And you know



that, too.
A. Okay.
Q. I mean, am I right on that?
A. I think it still has that designation. Tennessee has gone through -- different states go through different levels, but, yes, it is --
Q. And this is sort of a background for my question. What designation level care would you be providing at the urgent care facility, how would you designate it here in Mississippi? Your facility?
A. There's no such designation.
Q. Well, I mean, for example, Baptist here in Oxford, Baptist Hospital, does it have a designation as to level of care it can provide in its emergency department?
A. The trauma -- it has a designation from a trauma standpoint. In other words, there is some trauma money -- I mean, there is federal money and there is designations of federal trauma centers, but only as the treatment relates to trauma services. So in other words, it is a -- Baptist Hospital, I believe, is a Level II trauma center designation. And only hospitals are designated under the trauma system, and some are -- most are Level III. Baptist may even be Level III, but it has to do with the



amount of staffing, and so a number of possibilities, so -- you know, but it's only a hospital and it's only related to trauma.
Q. So you would have no trauma designation for your urgent care facility?
A. As any other non-hospital facility would, that's correct.
Q. And I guess I'm just trying to get an idea in my mind the difference between urgent care facility and the emergency room in a hospital, you know, as far as the care and treatment that can be provided to a patient. Can you describe that for me?
A. Well, an urgent care setting by definition is not in a hospital. And therefore, it lacks, you know, some of the resources which a hospital needs. So when we identify patients who need a level of care as a for instance, admission to a hospital, we refer them to a hospital rather than we don't have any way to hospitalize people or way to deliver some of those services. So, for instance, if you need surgery, you would have to go to a hospital. We don't have a CT scan or a CAT scan. We actually order them at the hospital.
Q. All right. So would a fair way to characterize the difference between urgent care

facility, like the one that you all have, and an emergency room be it's a lower level of care for emergency patients? And if there's a better way to characterize it, please, do so.

A. It's a different site. It's not hospital based.

Q. It's obviously a different site and there is no hospital, but is there any difference in the level of care in treatment that the patient receives in an urgent care facility compared to an emergency room at a hospital?

MR. O'DONNELL: Object to the form as vague in terms of the term level of care.

A. Certainly more services can be provided in a hospital than in a non-hospital setting, yes. So, yes. More services can be provided in a hospital than in urgent care.

Q. Well, let me ask you this. You've read the records with regard to Princess Anderson and her emergency room visit to Baptist DeSoto Hospital, have you not?

A. I have.

Q. All right. And let's pull those records. Pull those records for me if you have those.

A. Right there.



Q. The clinical impression with regard to Princess Anderson for her admission to Baptist DeSoto on February 7th was what?

MS. BANKS: What number is that at the bottom?

Q. I'm looking at BMHD30, where it says clinical impression. Do you see that?

A. Yes. Do you want me just to read that?

Q. Yeah. What was the clinical impression?

A. Okay. There was apparently two things written in one hand at one time, drug reaction and positive pregnancy.

Q. All right.

A. And then in another hand out to the side, so apparently added later, was acute psychosis and substance abuse.

Q. And you understand that there were two different physicians that took care of Ms. Anderson?

A. That's right.

Q. But all those, the drug reaction, the pregnancy, the acute psychosis, and the substance, what did you say?

A. Substance abuse.

Q. -- and the substance abuse, were all part of the clinical impression with regard to this



patient, right?

A. Apparently -- I don't know if they were all part of that. In other words, this may have been two physicians and the first physician had the impression drug reaction and pregnancy, and did not consider acute psychosis or substance abuse as diagnosis. The second physician may have added those two.

Q. I understand --

A. One physician or another thought that, yes.

Q. Right. But, I mean, that's part of -- when you go to the emergency room you might get taken care of by two physicians?

A. It certainly happens.

Q. And both physicians contribute to the record, to the charge?

A. That's right.

Q. So there's a specific designation in the chart for clinical impression by whatever physician is handling this patient, even if it's more than one?

A. That is correct.

Q. And so the diagnosis, whether it's by one or both physicians, regardless, the diagnosis, or clinical impression, was drug reaction, positive pregnancy, acute psychosis, and substance abuse for this patient.



MR. O'DONNELL: Object to the form.

MR. DAVIS: Object.

Q. Is that not right?

A. They wrote them in the clinical impression. The diagnoses that were assigned to this chart probably wasn't done here, but on a different form with a CBT. So that's the clinical impression. I don't know if it's the specific diagnosis that they used.

Q. Well, clinical impression, let's use that.

A. That's right.

Q. And I didn't mean it to be such a controversial question, but what I was getting to was this. But my question is this, given those clinical impressions, is that the kind of patients that would be seen at an urgent care or is that the kind of patient that would be referred to an ER at a hospital?

A. Well, this kind of patient I see, if you're asking about my specific experience -- is that what you're asking about or in general about this kind of patient?

Q. I'm asking about urgent care facilities like your facility.

A. Yes.

Q. Not you personally, but I'm talking about urgent care facilities.

A. Yes.

Q. Would this be the type of patient that an urgent care facility would see and treat or would this be the type of patient they would say, hey, this person needs more care than we can offer here at the urgent care, we're going to send this person to the emergency room?

A. This kind of patient would certainly be a kind of patient that we would see and treat. The ultimate disposition may be that they need to go to a hospital. But, I mean, we certainly see this kind of patient at the jail. I see this kind of patient at my urgent care, at my jail, and my substance abuse treatment facilities. Some of them we treat. Some of them we say need a higher level of care.

Q. I'm just trying to be specific here, with regard to Princess Anderson, you've seen the record at Baptist DeSoto, and let's exclude the jail and your addiction facility, I'm just asking about the urgent care because originally I was trying to find out from you the difference between urgent care and emergency room. Do you understand that?

A. Uh-huh (Indicating yes). I mean -- I do



understand.

Q. So my ultimate question is, given you reviewed the entire chart -- let's get away from the clinical impressions because that's obviously throwing everybody, but you reviewed the entire chart. Is this the kind of patient that if she came to your urgent care facility that y'all would say, hey, this person needs to go to the emergency room to be medically cleared to go wherever she needs to go, or would you all be capable of medically clearing her there at your urgent care facility?

A. Well, first of all, I think that it's important for me to say that I wasn't retained to give an opinion about -- I mean, I wasn't retained to review the records from Baptist DeSoto with an opinion about whether she could be treated in an urgent care or not. So, I mean, that wasn't the purpose of my review of the record.

Q. I understand.

A. A person with similar kind of symptoms to Princess Anderson who was brought by ambulance and who was under psychiatric commitment would likely not have been treated in the urgent care setting, but would have likely been treated in an emergency department. So even if they had presented to my



urgent care, would be referred on. But she was brought by EMS. She wouldn't have been brought to an urgent care setting to begin with.

Q. Okay. Can you tell me what's on the disk here just for the record?

A. I believe that is your -- no, the documents that came from Baptist -- they're big files of Baptist records. And I think some of them may have even been printed, but there's some 542 page things -- some of them were even -- the 542 was actually 250 twice or something. It was almost the same record that was duplicated, but it was those big Baptist records and I don't know who provided them.

Q. So that would be the Baptist records after Princess Anderson was taken from the jail to ultimately Baptist DeSoto?

A. No. I think there's -- I think there's the Baptist DeSoto record. I think there is the Baptist Union County record. And I think -- the next and then the final Baptist DeSoto. I believe all of those are on there. Those are all Baptist records.

Q. Okay. And I know I got away from this, but we were going through what you had in your file. Did you bring your entire file with you?

A. Yes.



Q. Did you pull anything out of it before we got started here?

A. No.

Q. You've got the chart for Baptist DeSoto. I don't see any -- other than what's written BMH DeSoto on the top, I don't see any other writing, any notes made on that?

A. That's correct.

Q. So I'm not going to mark that as an exhibit, but for the record it goes from BMHD26 through BMH85, correct?

A. Okay.

Q. And then you have a copy of the Marshall County Detention Facility Policy and Procedure Manual, correct?

A. Correct.

Q. All right. Of course, this is not Bates stamped. I don't think anybody's Bates stamped it yet. But I don't see any marks on here other than one that looks like it was actually marked probably not by you --

A. That's right.

Q. -- so you didn't mark that up any?

A. That's right.

Q. I'm not going to mark that as an exhibit

either. You have Dr. Richard Sobel's report and CV, etcetera, correct?

A. Correct.

Q. Let's take a look and see if you made any notes or marked it up. You did make a few marks on this one so we'll mark this one as --

MR. CZAMANSKE: David, how do you want to do this? Do you want me to mark his that are here and then somebody will copy them or what do you want -- how do you guys want to do that? Because I want to make this Exhibit 2 because it's got notes on them.

MR. O'DONNELL: You can just make that the exhibit and we'll just work through the court reporter on that.

MR. CZAMANSKE: Okay.

(Exhibit No. 2 was marked.)

Q. So Exhibit 2 -- and it may be confusing because it's got a photograph Exhibit 1, but I'm going to put Exhibit 2 on the left corner and I'm going to note "depo exhibit."

MR. O'DONNELL: I think Exhibit 1 is your reference --

MR. CZAMANSKE: Yeah. Just so the record is clear, it's going to have an exhibit



sticker that says "Depo EX" on it.

Q. I'm just looking at your notes on this. You put a little bracket where Dr. Sobel says that he has served as a reviewer of medical standards under EMTALA for professional review organizations hospitals, and forensic setting. Was there any significance to that or why you did that?

A. I just -- it was a credential which I had -- which I was -- it was a credential which I noted that he had -- you know, that he had testified or had reviewed about before. And so in addition to other stuff, it was just a notation of his -- of a specific review he had done before.

Q. Have you ever been a reviewer of medical standards under EMTALA, professional review organization?

A. Is your question, have I ever been -- have I ever reviewed those standards?

Q. No, no. Have you been a reviewer of medical standards under EMTALA for professional review organizations, hospitals --

A. No.

Q. -- or in a forensic setting?

A. No.

Q. On Page 3 of what I marked as Exhibit 2 for



this deposition you note an HR -- you wrote down HR equals 150 hyperventilation.

A. Uh-huh (Indicating yes).

Q. Was there some significance of that to you?

A. Yes. I was making notes -- things that I thought were pertinent in the record. And so there was a record of a heart rate of 150 and she was hyperventilating when she arrived.

Q. Do you agree with that based on your review of the records?

A. That was the report from the EMS, yeah, I mean, that's what was going on with her, yes.

Q. All right. You wrote down -- below that you wrote down "acute psychosis" in the column on the right. Is it your opinion that on the February 7th visit to Baptist Hospital DeSoto that this patient, Princess Anderson, was suffering from acute psychosis?

MR. O'DONNELL: Dan, you're getting into areas that Dr. Fowlkes has not been retained to provide opinions on. As long as we're clear about that. I mean, you can ask him if he happens to have an opinion on it.

MR. CZAMANSKE: I'll rephrase it. I was just going on his notes.



Q. I wasn't trying to pick on you. But do you have an opinion as to whether or not Princess Anderson at her admission and ultimate discharge from Baptist DeSoto on February 7th through February 8th was suffering from acute psychosis?

A. I do.

Q. What is your opinion?

A. She was not.

Q. Okay. You have a number -- on Page 4 you have a number of symptoms written down in the right column. Do you see that? Maybe not symptoms is not the right word, but a description of --

A. Behavioral descriptions. Yes.

Q. Thank you. Why did you write those behavioral descriptions in that column?

A. Well, they are -- the reason they're written over here where they are is they're direct quotes or close to it from over here in the text at these places. And I was trying to describe what her behaviors were at Baptist DeSoto. So these were ones that your expert was describing at Baptist DeSoto, so I was basically, rather than underlining I was maybe rephrasing somewhere along the way. But, essentially, writing what your plaintiff -- your expert's description of her behaviors were at Baptist

DeSoto and this is a list of some of them.

Q. Did you disagree in any way with his description of the behaviors?

A. No.

Q. Was there some significance to those behaviors to you with regard to your opinions in this case?

A. Yes.

Q. Tell me what that was.

A. In my report I described symptoms that Ms. Anderson had at Baptist DeSoto on Page 5 of my report.

Q. Okay.

A. I paraphrased or rewrote many of those same symptoms and described her behaviors at Baptist DeSoto, which were similar to descriptions of her behavior at jail.

Q. Okay.

A. So it was notes where my later report.

Q. On Page 5 of that report you wrote down "excited delirium." Do you see that up on the upper right?

A. Yes. He had made reference to excited delirium and I was calling attention that he had called it excited delirium.



Q. Are you familiar with excited delirium, that phrase?

A. I am.

Q. Is that a medically recognized phrase?

A. It remains controversial.

Q. What's your understanding of excited delirium?

A. My understanding of excited delirium is it's a synonym of agitated delirium. You'll also see that term as well. Those mean the same thing. Though are really more legal terms or law enforcement terms than they are medical terms to describe a scenario in which a person is exhibiting acute delirium usually in the setting of a substance ingestion. They're acutely delirious. And it's usually used in the setting of there were -- they have an encounter with law enforcement or with some other people who restrain them, and then suddenly the person dies and it's an attempt to -- or it describes that scenario. It describes that syndrome where a person was exhibiting an agitated state. They were delirious. They fought with law enforcement personnel, were restrained and then died.

Q. Okay.

A. And it doesn't explain why they died. It



just explains that scenario.

Q. All right. I thought I had pulled together the ones I wanted to go through with you and sat them in a separate pile, but apparently I didn't. Let's finish going through your documents here. You've got the Department of Mental Health Pre-Evaluation Screening Form, which is Core Disclosure -- MCKD Core Disclosure 65 through 68. You reviewed that?

A. Is this the one from Baptist DeSoto? No, this is the one from Marshall County. Okay. Yes, I have reviewed it.

Q. Is that something that Marshall County would have had when they received this patient?

A. No.

Q. What's your understanding as to who had that document?

A. This document was prepared by a master's level mental health therapist who works for Communicare, which is the designated community mental health center for Marshall County. And she performed this evaluation on 2/9, so a day after Princess got there.

Q. All right.

A. And it's my understanding based on my experience as the physician examiner who reviews



these record from Communicare, that she was preparing this for the physicians who were going to see the patient the next day.

Q. Do you know Debra Shelton?

A. I do not.

Q. You never met her?

A. No, I've never met her.

Q. I was thinking she was here in Oxford for a while, but I could be wrong on that. Have you dealt with Communicare before?

A. Yes.

Q. In what setting?

A. That very setting. I've been the evaluator for psychiatric Writs for Communicare -- I'm sorry, not Communicare, for Lafayette County, for the last 15 years, and Communicare does the prescreenings for us.

Q. Okay.

A. So I review those on a weekly basis.

Q. Is it your testimony that based on your experience that this information, the pre-evaluation screening form is not provided to the jail?

A. Well, you asked me -- your question was would they have had it when she was admitted there. And, no, they wouldn't have had it when she was

admitted there because it wasn't prepared till the next day. But, no, she wouldn't leave this with the jail. It is my experience you would not leave that with the jail.

Q. Is it your experience that the Communicare folks discussed with the jail their evaluation on the inmates?

A. No, they do not.

Q. You've seen the Writ to take in custody?

A. Is that for DeSoto County or Marshall County?

Q. Marshall County. It's marked MCKD Core Disclosure 69 through 70. Would the Writ to take into custody, would that be based on your experience, if you know -- and if you don't know, tell me -- but would that be something that would be provided to the Marshall County Sheriff's Office?

A. It would be, but it was -- it actually had to be prepared the next day, but it would have been faxed back over to the -- she was -- that was the one that was prepared on February the 9th the next day after she was brought there. But, yes, it would have been provided to them.

Q. You reviewed the pathological -- basically what I would call an autopsy report, with regard to



Princess Anderson, correct?

A. That is correct.

Q. I don't see any notes. Did you make any notes on it?

A. No, I did not.

Q. You reviewed the booking report marked MCKD Core Disclosure 1 through 8.

A. I did.

Q. In your capacity working for the jail that you work for, do you -- do they have a similar type of booking report?

A. They do.

Q. Do they have a similar type of medical condition, health history profile that they'll do on the inmates?

A. They do.

Q. And as medical director there at the jail, do you have an understanding as to why the county jail would put together a medical health history profile?

A. Yes.

Q. What's your understanding as to why they would do that?

A. To identify medical condition -- medical and psychiatric conditions that require attention.



Q. Including suicidal tendencies?

A. Yes.

Q. And is it based on your experience the inmates that have the psychiatric issues and the suicidal tendencies require normally under their protocol or their, what do you call them, their policies and procedures, they require more supervision than a normal inmate?

A. Yes.

Q. And can we agree that with regard to Princess Anderson there was an indication on the medical condition health history profile suicidal tendencies and psychiatric care?

A. Can we agree that those boxes are checked, is that what you're saying?

Q. Yeah.

A. Yes. Those boxes are checked.

Q. Isn't that significant with regard to the supervision she's going to receive at the jail?

A. Well, more significant was -- no, not really, not what was marked on there. What's significant is that she was brought there under a court order for psychiatric treatment. Automatically -- irrespective of what would be checked there, she should be treated in the fashion that psychiatric



commitment patients are treated.

Q. Based on your review of the policies and procedures of the paperwork, how often was she supposed to be checked on by the jail staff?

A. She was supposed to be held in -- apart from other inmates and checked on frequently.

Q. But how -- can you give me more than -- other than saying frequently, can you give me a time, how often time-wise she was supposed to be checked on?

A. I would have to review that for the specific time, but I know that all -- what I know is that all patients -- yes -- I wasn't trying to be argumentative. And yes, because if she had suicidal tendencies and psychiatric care, she should receive additional increased monitoring, increased supervision, kept separate from other patients. But that should occur not as a result of this checkmark here, but by the fact that she was a psychiatric -- so in other words, they have a policy of dealing with all psychiatric commitment patients that has that increased level of screening and increased level of monitoring whether those boxes were checked or not.

Q. And I just want to be clear so we're on the same page. Are you saying that if somebody who's

committed and they're going to jail under the policies and procedures for Marshall County, that they're going to be checked on the same regardless of whether there's any indication of suicide tendencies or not?

A. The Marshall County Jail and other jails, there are state regulations about handling those psychiatric patients. So, yes, whether they were suicidal as part of their psychiatric commitment, I mean -- I mean, they're known to be -- that is by definition they're psychiatric patients. So in other words, it doesn't really matter whether they had this box checked or not. But they're presumed to be -- that is the whole reason that they're there. You have to be a danger to yourself or others in order to be committed. So that is by definition the treatment that they'll receive.

Q. You've got the statements from the various jailers. These aren't Bates stamped, so let's -- you've got the statement from Alnita Kimmons, jailer. You've reviewed that, haven't you?

A. I have.

Q. You've got the statement from Ardella Anderson. You've reviewed that, true?

A. I have.



Q. You reviewed the booking log that's marked MCKD Core Disclosures 9 through 34?

A. I have.

Q. And you've reviewed that. I didn't see any marks on there. Did you mark that up at all?

A. I did not.

Q. And you've got the records from Holly Springs Hospital, Alliance Healthcare System, and you reviewed those, right?

A. I have.

Q. And those are marked -- well, I don't see a Bates on them, but we all know what they are. I'm not going to mark those. I'm going through a list of what you've got here in your file. You've got the records from the Baptist Memorial Hospital Union County?

A. Yes. Can I explain something to you for just a second?

Q. Sure. Go ahead.

A. These records are -- I think they were on that disk. This is for however many pages that I thought were particularly relevant of those 500 pages. So those are the relevant pages off of those 542.

Q. Got you.



A. Even if I ultimately decided they weren't relevant, they were the ones I wanted to print off. See, that's --

Q. Yeah, I was going to ask, what are the numbers on the upper right?

A. There's 446 pages of records and that would go at the page number these were.

Q. I tell you what, I'm going to go ahead and mark that as Exhibit 3 since they're selected copies.

(Exhibit No. 3 was marked.)

Q. We'll keep those separate because we're going to go through some of the medical stuff so I want to keep those out. You've reviewed the deposition of Dr. Sobel it looks like?

A. Yeah, I have reviewed that preliminary -- I mean, I'm not sure that it's the version that is final. It was a draft copy.

Q. A signed version?

A. I'm not sure. It is what I was provided. And it's obviously printed four pages -- I printed it on my own computer from a PDF.

MR. CZAMANSKE: I'm going to mark this as Exhibit 4.

(Exhibit No. 4 was marked.)

Q. I'm doing that because you've got notes on



this one.

A. That's fine. Do you mind if I look at it -- this and this just for a second?

Q. Go ahead.

A. (Perusing documents). Essentially, if I'm not mistaken, these may have been done at separate times, but this is all notes on the Baptist Union. This is all really one thing. I don't know -- I'm not exactly sure why there's -- this is notes from -- that's notes -- and it may be double. Sort of doubled. But it's all related to the Union. Some of those are even the same page numbers. It's all one pile. I don't know how it got into two separate --

Q. Okay. We're just going to include that.

A. That's what I'm saying. That's really one pile --

Q. It should all be part of Exhibit 3?

A. All one document. That's right.

Q. They're all records from Baptist Union?

A. That's right.

Q. You've got a couple of -- these looks like notes maybe that you put together. Is that true?

A. Yes, that's right. They were notes that I put together for you.

MR. O'DONNELL: That's correct. I've

looked at those.

MR. CZAMANSKE: I'm going to mark the notes on Altered Sensorium as Exhibit 5.

(Exhibit No. 5 was marked.)

MR. CZAMANSKE: And the notes on Mississippi Civil Commitment Law as 6.

(Exhibit No. 6 was marked.)

Q. Then we've got it looks like your report but your report with notes on it.

A. That's right.

Q. Is this an earlier report that was revised or is this just some notes maybe you had on a conversation?

A. This is notes that I had -- that I made on that after reading Dr. Sobel's deposition.

Q. Okay.

MR. CZAMANSKE: We're going to mark that as Exhibit 7.

(Exhibit No. 7 was marked.)

Q. Then you've got another copy of the policies and procedures, but this one appears to be -- have some earmarks --

A. Let me see if this is -- yes. This is -- I did earmark sections that I believed were relevant to medical procedures and stuff.



Q. Let's set this aside. We're going to go through that separately. You've also got the Baptist Memorial Hospital DeSoto's Expert Designation that you have notated, right?

A. Yes.

MR. CZAMANSKE: We're going to mark that as Exhibit 8.

(Exhibit No. 8 was marked).

Q. And I want to go through this a little bit with you, so I'm going to pull out here Baptist DeSoto's records, which I believe we marked as Exhibit 3; is that right?

A. No. This is the Baptist Union County's.

Q. Excuse me. I'm sorry. That's Baptist Collierville.

A. That's right.

Q. What did we do with Baptist? Did we not pull those already?

A. I think you set it to the side.

Q. I'm sorry.

A. It's all right. It's right there. First of all, let me ask you if you're familiar, especially having worked in the emergency room department with --

MR. O'DONNELL: Can we take a short break?



MR. CZAMANSKE: Yeah. I'm changing topics, good time to take a break.

(Short recess).

Q. I wanted to ask you about the Baptist DeSoto records. Okay. And they're Bates stamped BMH-D. And I know you've worked in emergency rooms, and I'm looking at BMH-D34, which, guys, it's this one. It's the protocol. You're familiar with standing orders in emergency room departments?

A. I am.

Q. And you probably can describe it better than I can, how would you describe standing orders?

A. Standing orders or a more appropriate term is probably protocols for certain scenarios. So given certain scenarios, there are certain standard orders that expedite care and ensure that standardized and good care is delivered.

Q. And there's a set of standing orders for various conditions that are set forth there on BMH-D34, right?

A. That is correct.

MR. DAVIS: Object to form.

Q. As part of the record you reviewed in this case?



A. That is correct.

Q. There is a section called Altered Mental Status. It's the third box on the left side. Do you see that?

A. I do.

Q. Based on your review of the records, did Princess Anderson, would you as an emergency room doctor categorize as suffering from altered mental status?

A. Yes.

Q. Do you see the orders that are listed in there?

A. I do.

Q. Were any of those orders carried out?

MR. DAVIS: Object to form.

Q. Or protocols I guess I should call them? Well, let's go through them. Was a CBC done?

A. No.

Q. Was BMP done?

A. No. I was just looking down through there for just a second. I think that a saline lock, or I think an IV may have been started and then was pulled out. That's the only one of those that I see. And cardiac monitor, also. So two of those were done.

Q. And urinalysis was done?

A. Yes, that's correct.
Q. And urine drug screen, the next one. UA, UVS and cardiac monitoring. And in addition to that, CT head, which is not on there. It has to be ordered separately.
Q. But the CT head was done?
A. That's right.
Q. Was there a finger stick for blood sugar?
A. I do not believe so.
Q. Was she given 02?
A. I do not believe so. It says pulse oximetry next and that was performed. It was.
Q. Oh, it was? I didn't see that.
A. You'll have to look in some of the nursing notes, but you'll see it where it will describe -- I saw where Dr. Sobel said it wasn't done, but -- like right there, that's pulse oximetry.
Q. Let's get a page. You're looking at 39?
A. Okay, 39, SA02, that's pulse oximetry 100 percent. So her Oxygen level was 100 percent, so she didn't need Oxygen.
Q. Right. So some of the protocols were carried out and some weren't?
A. That's right.
Q. And you know working in emergency rooms



there can be multiple diagnosis on a given patient?
A. That is correct.
Q. So there can be -- multiple protocols might be applicable to that patient?
A. That is correct.
MR. DAVIS: Objection.
Q. If you go to the middle column right about the middle there is a protocol for medical clearance for psych evaluation?
A. That is correct.
Q. That would apply to Princess Anderson?
A. It would.
Q. Under that protocol CBC is called for. That was not done, was it?
A. Not at this visit.
Q. Not at this hospital?
A. Not at this hospital. That's correct.
Q. And not for this admission?
A. Not at this ER and not during this admission, no.
Q. And BMP, that was not done, was it?
A. It was not.
Q. Alcohol level, that was not done, was it?
A. That is correct.
Q. And then over on the right column there is



pregnant with abdominal pain. Do you see that, very top one?
A. I do.
Q. Would that apply in this instance?
A. I don't believe so because it was adequately worked up at Collierville.
Q. And then on that same column but down see where it says suspected overdose?
A. I do.
Q. Would that apply?
A. It would.
Q. We've gone through the -- I mean, it's fair to say no blood was drawn at all at Baptist DeSoto?
A. That's correct.
Q. Acetaminophen level, that's one that wasn't in the other protocol?
A. Right.
Q. How do you get that?
A. That is a Tylenol -- that's a Tylenol and overdoses should be screened for Tylenol because it's -- it's potentially lethal if untreated and potentially very treatable if it is. So because many people won't tell you that I ingested Tylenol, if you suspect an overdose you ought to check the Tylenol level.



Q. And I was wondering how do you check it, do you check it with the blood or urine?
A. Blood level.
Q. Blood level.
A. And same with salicylate. That's Aspirin. The next one is Aspirin.
Q. We've already gone over the finger stick. Cardiac monitor. You're saying she was on cardiac monitor, right?
A. Yes.
Q. EKG protocol, do you know what that is?
A. I do not.
Q. All right. Now in looking at the Baptist DeSoto designation of expert, you have some notes written on here, and I'm going to go to Page 2.
A. Could you turn it around?
Q. Yeah, so we can both look at it. There at Page 2, it states that Dr. Carlton was anticipated to testify as an emergency room physician staff at BMH-D. You understand that to be Baptist Medical Hospital DeSoto, right?
A. Baptist Memorial DeSoto.
Q. You're right. During emergency room admission of Princess Anderson on February 7 through 8th complied with the governing standards of care in

all respects with regard to their evaluation, care and treatment of Princess Anderson. And I didn't finish reading the whole paragraph, but you write down "disagree" over here.

A. That is correct.

Q. What part do you disagree with?

A. That they complied with the standards of care with regard to evaluation, care, and treatment.

MR. DAVIS: Object.

MR. O'DONNELL: We have not tendered Dr. Fowlkes to testify as to standard of care delivered at Baptist DeSoto prior to the time that Ms. Anderson was brought to the jail February 8, 2011. But he has reviewed the records. It's outside his designation. It's outside of the retention, so we'd object to those questions on that basis.

MR. CZAMANSKE: I understand.

Q. Dr. Fowlkes, one of the issues we're looking at in this case is, with regard to the defendants, is who has what responsibility with regard to Princess Anderson, isn't it?

A. It is.

MR. O'DONNELL: Calls for a legal conclusion.

Q. And one of the issues in this case is



whether or not at the time she's transferred to the jail is whether or not she was in a condition that she should have been transferred to the jail. Isn't that part of the issue in this case?

A. Well, I was asked to review Marshall County's role in this and the jail's role in this. And so the view with which I reviewed this case was that whether I personally disagree with the care that she did or didn't receive at Baptist DeSoto, she was determined to be medically clear and determined by physicians at Baptist DeSoto to be medically clear to not require hospitalization and not require prescriptions to not require any further ongoing, you know, any further care, and was medically clear to be at Marshall County Jail, which they knew was a nonmedical facility. So that is the presumption under which she came to Marshall County Jail and what they could or should have known.

Q. I understand that. And part of the issue you have to consider is that person, Princess Anderson, her underlying condition while she's at jail. That's part of your opinion, isn't it?

MR. O'DONNELL: Object to the form. Vague.

MR. CZAMANSKE: Let me try and



rephrase it.

Q. Isn't it part of your opinion to look at her underlying medical condition and the symptoms she had in that condition or the symptoms --

A. Yes.

Q. -- she didn't have in that condition while she's in jail?

A. Yes.

Q. And to do that you have to look at her condition when she came into jail?

A. That is correct.

Q. Her medical condition.

A. Her -- what I have to look at is her -- the symptoms she was demonstrating, her behavior that was demonstrated to the jail staff as opposed to or as compared to the symptoms she was exhibiting at Baptist DeSoto where trained medical professionals saw her, determined that she was medically clear, determined that she was safe and stable to be in a jail environment. So what I reviewed in my records was did her behavior, did her symptoms, did the things that the jailers were seeing, did they deliver substantially from -- in other words, was there a deterioration in her condition. Because the hospital had seen her and declared that she was medically



stable to be in the jail and had no conditions that required her to be in the hospital.

Q. So did you consider as part of your opinion Princess Anderson's underlying medical condition at the time she's transferred from Baptist DeSoto to Marshall County Jail?

A. I did.

Q. And one of the ways that you're going to determine her condition is by looking at the medical records for Princess Anderson before she went to that jail?

A. I did.

Q. And part of the thing that you're going to look at and consider as an expert in determining her medical condition before she goes to jail are tests that were run on her?

A. That is correct.

Q. And the results of those tests?

A. That is correct.

Q. But you also have to consider what tests weren't run on her, don't you?

A. That is correct.

Q. And what tests should have been run on her?

MR. DAVIS: Object to form.

A. I did -- I considered the result, the

result more so than anything else. In other words, she had been determined by the physicians to be medically clear.

Q. You're not endorsing that determination in any way, are you?

A. No.

Q. You don't -- based on what you've told me, you don't even necessarily agree with their decision to medically clear her for --

MR. DAVIS: Object to form.

MR. CZAMANSKE: Okay. Wait till I'm done.

Q. You don't agree with their decision to medically clear her for the jail setting, do you?

MR. DAVIS: And just to save time, will you give me a standing objection?

MR. CZAMANSKE: I sure will.

A. That's correct.

MR. O'DONNELL: And, of course, we're objecting to the extent that he's being asked to offer opinions beyond the scope of his retention and his report.

Q. On Page 5 of the designation --

MR. O'DONNELL: Which designation?

MR. CZAMANSKE: I'm sorry. Thank



you. Baptist DeSoto. I marked it as Exhibit 8.

Q. On Page 5 there's a note about consult under the lower third, I guess, of the page there.

A. Right.

Q. And explain to me what you mean by the comments you have written down there.

A. Princess had been seen earlier in the day at Baptist Collierville where she was determined to be pregnant, and the ultrasound findings were suspicious for an ectopic pregnancy. So we had a potential ectopic pregnancy and what that calls for is in 48 hours having another, at least, quantitative HCG to be done in 48 hours. Which by this time would then be the next day, so 24 hours essentially from the morning of being at Baptist DeSoto. And so basically I made a note here that Baptist DeSoto consulted with an OBGYN who said that there's no medical reason to admit her because of her pregnancy, although follow-up was needed within a few days. Few days is not true. She needed 48 hours from the first time her blood was drawn, which would now be 24 more hours. And it was incumbent upon them to see that that was done.

Q. And you noted that not able to -- not able to reliably follow-up, should have admitted. Is that



what your note is?

A. Well, it is appropriate for outpatient care. This condition is appropriate for outpatient care if you can assure good follow-up. In other words, if she could -- if she had told the jail that -- they had told the jail that she needed a blood test the next day or something. But in the absence of the ability to follow-up ordinarily you would need to be in the hospital.

Q. And my original question was, if I read your note right? "Not -- in quote, "not able to reliably follow-up - should have admitted." Did I read your note right?

A. That is correct.

Q. And is the reason that you noted not able to reliably follow-up because of Princess Anderson's mental condition at the --

A. Yes.

Q. -- time she was at Baptist DeSoto?

A. Yes.

Q. So really in that regard, you agreed with Dr. Sobel on that one particular issue?

A. Yes.

Q. And Page 7 of Exhibit 8 you note that -- explain your note there where it says "no, Writ



only."

A. Basically this says a commitment order and technically that is not true. A commitment order had not been issued, only a Writ of commitment. So only the detainer of Writ had been issued. She has not been court ordered to involuntary treatment at that time, only a Writ.

Q. That's just a different -- they just hadn't got to that point in the process?

A. That's correct. So she was not ordered for involuntary psychiatric treatment at this point. She was ordered to detention.

Q. On that same page, Page 7 of Exhibit 8, where it's noted Dr. Carlton disagrees with Dr. Sobel's opinion that the emergency room physicians breached the standard of care by determining that Ms. Anderson was medically stable for discharge for further psychological evaluation and treatment. You noted again your disagreement there, correct?

A. I disagree with Dr. Carlton's disagreement.

Q. All right. And would it be fair to say then with regard to that one particular issue you agree with Dr. Sobel's opinion?

A. Yes, that is correct.

Q. I should have asked you this, do you know

any of the experts involved in this case? Dr. Carlton or Dr. Sobel or any of those?

A. I know Rick Carlton socially. He's in the emergency medicine in Mississippi and I run into him at meetings. But other than --

Q. Are y'all social acquaintances? Go out --

A. In fact, I'm not sure I'd recognize him. You know, we all age. I'm not even sure I'd recognize him.

Q. Do you know Dr. Sobel?

A. I do not.

Q. Do you know any of the emergency room physicians involved in this case, Dr. Olmstead or Dr. Black?

A. I don't. I've seen both of their names, but I don't know what either one of them look like and don't know them.

Q. On Page 8 of the opinion where it indicates that laboratory testing did not reveal any organic or metabolic basis for her prior delirium and she was not otherwise medically unstable you note, quote, did not do labs or tox testing. Did I read that right?

A. That's right.

Q. What labs or tox testing -- are you talking about the ones we went through on the protocols?



A. That's correct. It said as laboratory testing did not reveal, and the opinion was that limited amount of laboratory testing was done.

Q. The urinalysis that they did, can you turn the page there?

A. The one at Collierville or the one at Baptist?

Q. The one at Baptist.

A. Okay.

Q. Because I had a question about this. You see the specific -- is it the specific gravity? You know what, let's not --

A. Don't mark --

Q. You know what, that's your copy, I guess if you want to mark on it you can. That's fine. The specific gravity, what's the range for specific gravity?

A. In this laboratory 1.003 to 1.030, and anything over 1.030 is listed as greater than. So that's concentrated. Although Baptist DeSoto has a different range because theirs earlier in the day was 1.034 and it was reported --

Q. Baptist Collierville?

A. I'm sorry, yes. Baptist Collierville.

Q. And that's where I was going. I was



looking at that and I wanted to ask about that because the -- have you ever worked with Baptist DeSoto before? Have you ever gotten labs from them?

A. Yes.

Q. And you've gotten labs from other places, so I wanted to ask you. With regard -- what's the significance of Princess Anderson's urinalysis and the specific gravity on February 7 -- no, it's actually dated February 8th.

A. At 4:00 a.m.

Q. At 4:00 a.m. What's the significance of that finding?

A. Well, did you ask about the finding of the urinalysis only?

Q. I could have gone that way. Number one, what is the finding?

MR. DAVIS: What's the page you're on?

MR. CZAMANSKE: Seventy-four, BMH-D74.

A. The urine is concentrated. Meaning in other words, that the urine -- there's not been -- the urine is concentrated and the person is retaining as much fluid as they can. So in other words, it doesn't necessarily indicate dehydration. It can be



an early sign of dehydration. But in any event, the urine is concentrated. All of our urines are concentrated in the morning, too. It reflects not a dilute urine. And there's other findings, as well.

Q. But the amount of the concentration is greater than 1.030?

A. Right. That's correct.

Q. I mean, that's based on the way they've got it written here there's a greater than sign --

A. Well, we don't know how much greater.

Q. Well, that's what I was going to ask. We know earlier it was 1.034?

A. Right. So it was greater earlier in the day and it's still greater. It's concentrated. You would call it concentrated no matter -- either of those things, it's concentrated urine.

Q. But the greater the concentration the more significant the finding?

A. Yes, that's right. But they don't measure anything other than 030 at most places, so in other words, this is considered concentrated.

Q. Right.

A. It's considered concentrated.

Q. Well, I mean, you can't assume that it's 1.030?

A. No.
Q. It could be any number above that?
A. That's correct.
Q. And that's significant with regard to her condition there at the hospital before she transferred to the jail?
A. I believe so.
Q. Okay.
A. But there's some other findings on here -- I mean, there's some other findings that are as well significant. The blood -- the dip blood is negative so she did not have Rhabdo. She did not have Rhabdo at this time.
Q. Rhabdo?
A. Rhabdomyolysis.
Q. You're saying Rhabdo -- if she did have Rhabdo it would result in blood in the urine?
A. It would result in the dip test being positive.
Q. And the dip test measures what?
A. It measures hemoglobin is what it's designed to measure. But in the case of Rhabdomyolysis it also reads myoglobin. So a finding of -- a hallmark of Rhabdomyolysis is dark urine, coca-cola colored urine with a positive dip for blood



which is supposed to measure hemoglobin, but in the case of Rhabdomyolysis also reacts to myoglobin. But down here, no red blood cells. So in other words, the dip test indicates blood is there, but when you look in the microscope you don't see red blood cells because there's not red blood cells. They're myoglobin.
Q. Did you read the testimony of Princess Anderson's mother? Was that one of the depositions you were provided?
A. No.
Q. Okay. So you're not aware of her testimony and her description of the urine sample that her daughter gave there at Baptist DeSoto, her description of the color and consistency?
A. I'm not -- I'm aware -- no, I'm not. There was a reference in Union County's records to having -- previously had dark urine. So I'm aware of that reference in Union County's, but I'm not aware directly of her mother.
Q. Well, and you would have been aware of it from reading Dr. Sobel's deposition?
A. Yes, exactly.
Q. But you didn't read that testimony. Did you ask for her deposition?



A. I don't recall even knowing that she had been deposed.
Q. Did they do a -- strike that. I can't read your note on Page 8 of Exhibit 8, right there in the right column, this bottom note. Could you read that for me? I can't read your writing. That's all.
A. Dr. Carlton disagrees with Dr. Sobel's opinion that the potential of an ectopic pregnancy required admission to the hospital. And I said that -- this is somewhat controversial, but I said disagree because lack of ability for follow-up. The same thing we talked about before.
Q. Okay. Page 9 of Exhibit 8, I can't read your writing on the right column there. What does that say?
A. Ms. Anderson's -- it's in reference to this sentence, Ms. Anderson's clinical course indicates an adequate response to the use of Ativan without anti-psychotics.
Q. What did you write on the side?
A. Did not send prescription and you would expect the symptoms to recur without more medicine. I didn't write with more medicine.
Q. You didn't write what? I'm sorry?
A. Would expect symptoms to recur without more



medicine.
Q. In other words, they were sending her to jail and that Ativan was going to wear off?
A. That's correct.
Q. With regard to Dr. Carlton's opinion that Ms. Anderson's mental state was not the result of reported marijuana and codeine based cough syrup you wrote down disagree and you underlined it three times.
A. Yes.
Q. I take that to mean you strongly disagree?
A. Yes.
Q. This is something that you deal with it sounds like at your addiction clinic?
A. Right.
Q. Something that you -- drug use, something where you're very familiar with?
A. Yes.
Q. Tell me why you disagree so strongly with that opinion.
A. I believe her mental state was an acute delirium that was caused by drug ingestion most likely something called purple drink.
Q. What's that?
A. And I'm sorry that I didn't put that. It

is Phenergan with codeine cough syrup, which is why she tested positive for opiates. It's one of the -- there are about three ingestants that could have caused the acute delirium that she had, and the most likely of them is purple drink mainly because of testing positive for the opiates. The other two, bath salts and synthetic cannabinoids don't have drug tests to go with them. So they could have existed.

Q. If we went with this scenario that you have, this purple drink scenario, is there a time period where you would expect the effects of the drug to wear off of the patient?

A. In general, 12 to 24 hours, but it's very variable and I've seen people remain in this condition for several days due to it. So it's very, very long. It's longer than the actual half-life of the medicine in the body. And it depends on also their underlying psychiatric conditions.

Q. Page 10 of Exhibit 8 where Dr. Carlton indicates that it would not have been appropriate for Dr. Black or Olmstead to admit Ms. Anderson, you have a note there. Could you read that for me because I can't read it at all.

A. The first sentence that I was responding to was, it would have been inappropriate for Dr. Black



or Dr. Olmstead to have admitted Ms. Anderson to Baptist DeSoto. Baptist DeSoto does not have a psychiatric unit and the medical floors are simply not equipped to handle psychiatric patients.

Q. I can read that. I couldn't read your note there.

A. My note is that it was a medical problem that she had, an acute delirium. She needed a medical intensive care unit, not a psychiatric ward.

Q. Are you still of that opinion today?

A. Yes.

Q. Just read for me what you have written down there again on Page 10, that last bottom note on the right column, right down there of Exhibit 8.

A. True, not applicable in this case. I'm referring to the excited delirium syndrome.

Q. Okay. Dr. Fowlkes, I'm looking at the Holly Springs Alliance Healthcare System records.

A. Yes.

Q. And specifically their urinalysis.

A. Yes.

Q. And I was trying to -- maybe you can help -- I was trying to read where it says blood. What's that finding? It's handwritten. I couldn't read that.



A. Large.

Q. Large.

A. Large amount. There are some people use one plus two plus three plus four plus. Some people use trace, small, moderate, large. And that's large, so four plus.

Q. All right. What are the other ways to measure myoglobin in the body? What other tests?

A. Well, the best test for myoglobin itself is to send off the urine for myoglobin, but that's not the best way to guide when it's Rhabdomyolysis.

Q. No. I'm just asking what test would it show up. Would it show up in blood tests?

A. Myoglobin itself would not. You would normally order CPK, creatine phosphokinase, which is an enzyme that is associated with muscle breakdown. When muscle breaks down more substance than myoglobin are released. And one of the main ones that we measure in the blood is CPK or creatine phosphokinase.

Q. Okay. I know you've got, and we're going to go through here what I've marked as Exhibit -- I think I marked it -- the policy and procedure manual for Marshall County. Maybe I didn't mark it. No, I haven't marked it yet. And I may not. I want to go



through the parts that you earmarked. But before I do that, in looking through your files I don't see the deposition of any of the jailers, administrators, 30(b)(6) depositions of the jail people. Do you have it? Did you ever read any of those?

A. Yes, I have reviewed those. In fact, I thought they were in this stack. We moved a different -- we had a different stack.

MR. O'DONNELL: He reviewed those. I have those in my office.

A. I didn't make any notes on any of them but I read them.

Q. Well, I'd like to know which ones you reviewed.

A. You'll have to get -- I can't tell you the names of them without -- he can check his stack of the ones I reviewed.

(Pause in proceedings).

A. This is Dr. Sobel. I did not review this piece of paper. I reviewed that document that you have.

Q. All right.

A. Stevella Faulkner, I reviewed.

Q. Would you have reviewed the exhibits to this deposition, as well?

A. I review these documents.
Q. But you see how there's exhibits attached like photographs and things like that, would you have reviewed those?
A. No. I review the deposition only. And I can't see the name on this one. This is Bobby Harris. Dr. Charles Skelton. Ardella Anderson. Alnita Kimmons. And Janice Rahman.
Q. I was going to ask if you had read the deposition of Loretha Harris, an inmate, but I understand we haven't received that transcript yet, so you couldn't have read that.
A. No, I have not read that.
Q. Have you been provided any information as to what she testified to?
A. No.
Q. I'm going to go through the policies and procedures. I don't think I'm going to mark this unless there's something significant. But 2.18 you underlined something there, and I just wandered what the significance of that policy and procedure was.
A. Actually, I did not underline it.
Q. Okay. You work with the Lafayette County Jail?
A. That is correct.



Q. Have you seen their policies and procedures?
A. Yes.
Q. Have you seen the policies and procedures of any other jail other than Lafayette County?
A. Yes.
Q. Which ones?
A. Prentiss County, Yalobusha County. I want to say Union County also. I believe Union County.
Q. Had you seen Marshall County's policies and procedures before being hired in this case?
A. I had.
Q. Have you ever been involved in drafting any policies and procedures for any of the jails?
A. Lafayette County. Not of the -- no. Lafayette County's but none of the others.
Q. So you have been involved in drafting polices and procedures for the Lafayette County Jail?
A. Yes.
Q. Like what areas of the policies and procedures?
A. As it relates to medical care of inmates.
Q. In the Marshall County policies and procedures under Admissions, Records and Release, Subject Classification 1.5, indicates that inmates



suffering mental illness or other health illnesses shall be housed in a separate area from other inmates. What's your understanding of how that policy is supposed to be carried out?
A. That the inmate should be housed in a single man cell to avoid injury to other inmates, to the person with the psychiatric illness or to other inmates.
Q. But within that policy it's okay to put them in the same pod as other inmates as long as they have a separate cell?
A. Yes, in general.
Q. There is a policy in Marshall County's polices and procedures with regard to restraints that you earmarked?
A. Can I read what I said -- not used.
Q. Yeah. I'm going to -- I should probably show it to you. No restraints were used with regard to Princess Anderson?
A. Not that I could find record of. Not that I could find documentation of or not that have any -- I believe to the best of my knowledge, no.
Q. In other words, when you looked through the jail logs you didn't see any notations of restraint?
A. Or in the deposition -- or in the



statements of the jailers or the depositions of any records that I have reviewed. No one -- I didn't see any reference to restraining of her.
Q. You starred policy under Title Separation, Subject Mental Disorder -- excuse me, Mentally Disordered/Disoriented Inmates, Section 1.0 with regard to the job of the jailer that is not to diagnose mental illness or emotional disturbance, but be on the lookout for the common behavioral signs or symptoms that could indicate problems with the mental illness or emotional disturbance. What are the most common behavioral signs or symptoms with regard that would indicate problems with mental illness or emotional disturbance?
A. Bizarre behavior, confusion, refusing to eat, refusing to keep clothes on, refusing to comply, being non-responsive, not answering questions.
Q. All those would apply to Princess Anderson, would they not?
A. Yes.
Q. With regard to --
A. Could I elaborate on my answer to the last thing you just said --
Q. Yes, absolutely.
A. -- all those would apply. Yes, they do

apply to Princess Anderson and she was there precisely for mental -- I mean, she was there precisely for that. So, I mean, she didn't even -- she was known to have -- they didn't have to be on the lookout for psychiatric illness, she was sent there specifically for psychiatric illness. She was known ahead of time to have that. So it certainly applied.

Q. Right.

A. I mean, she was psychiatrically ill, that was why she was sent there under the statutes regarding mental health.

Q. And what you gave us was a description of those behavioral signs?

A. That's right.

Q. The section of the same, I guess, Title, Section 2.4 indicates that if there's -- if the jailer thinks the problem is serious, the behavior should be reported to the jail administrator or chief deputy. Do you see that section?

A. I do.

Q. Based on your review of the records, was the jail administrator or chief deputy ever consulted in accordance with this section where -- let me start the question over. It was a bad question. It says if



you think the problem is serious, report the behavior to the jail administrator. Did you ever see any reports to the jail administrator in the jail records with regard to Princess Anderson's behavior?

A. I don't believe that paragraph applies.

Q. But my question was, did you see any reports to the jail administrator with regard to Princess Anderson's behavior?

A. I'm not aware of any reports to the jail administrator.

Q. Section 6 titled Medical Services with the subject Medical Procedures, Section 2.2A --

A. I can't read it from over here. Sorry.

Q. That's all right.

A. Okay.

Q. That deals with medical emergencies?

A. Yes.

Q. The first action that occurs on medical emergency is notification of the jail administrator or chief deputy, right? Under the policies and procedures?

A. That's what the policies and procedures say, yes.

Q. And that never occurred here where there was notification of the jail administrator or chief



deputy having a problem with Princess Anderson?

MR. O'DONNELL: Object to the form of the question.

A. I believe what never happened was a medical emergency.

Q. I understand. Along with that, you would agree with me that there was no notification at any time of any medical emergency with regard to Princess Anderson to the jail administrator or chief deputy? Can we agree on that?

A. I'm not aware of any notification and I'm not aware of any medical emergencies.

Q. Take a look through there and see if there are any other policies and procedures that you dog-eared or noted that I missed that we didn't go through that you think are applicable in this case.

A. I don't believe so.

Q. Do you believe there's a violation of any of the policies and procedures with regard to the handling of Princess Anderson during her detention there at the Marshall County jail?

A. I believe that the policies and procedures were substantially followed in this case. In addition to these policies and procedures, there are state mandated policies and procedures for dealing



with psychiatric Writs that are not part of this, but that the state mandates to be followed and I believe they were followed, as well.

Q. Do you have those with you?

A. I do. Right there.

Q. Thank you. I'm going to mark those, what you just handed me, Mississippi Code 41-21 --

A. There's multiple sections.

Q. Sure. I'm just reading along on the front page. -- 61.

MR. CZAMANSKE: I'll mark that as Depo Exhibit 9.

(Exhibit No. 9 was marked.)

Q. I'm going to Section 2.6 of the separation, the title Separation Subject Mental Disorder, Disoriented Inmates. It indicates there that when an order for mental evaluation is issued -- you see which paragraph I'm talking about?

A. Yes.

Q. Let me start with that. Was an order for a mental evaluation issued?

A. Yes.

Q. Notes that it's the responsibility of the jail administrator to make sure the admission packet is received and properly filled out and returned to

the state mental hospital. What's the admission packet?

A. That Communicare evaluation that was done and the paperwork associated with the Writ. So the order appointing an attorney, appointing physician examiners, the report of Communicare, the report of the physician examiners.

Q. And so would those reports -- well, according to their policies and procedures those reports are received, reviewed, to make sure they're properly filled out and then returned to the state mental hospital?

A. What that means is, when the person was ultimately transferred to the state hospital after the hearing that they would -- that the state hospital would receive all the necessary paperwork. So once a person is committed to the state hospital and they go, the state hospital doesn't want to be left with no information, so they need the pre-evaluation report, the report of a physician, the report of the hearing, the order for commitment, all of that is the admission packet to the state hospital, and when they went -- it needs to be complete and sent with the patient.

Q. And they did all that from the jail?



A. Well, the jail is the one that transports the person to the state hospital ultimately, and so it's the jail's responsibility to send that paperwork.

Q. Yeah. It's the jail administrator's responsibility?

A. When they transport the person to the state hospital to send it to the state hospital with the patient, which never occurred in this case.

Q. Okay. Is that the way it works at Lafayette County as well, that it's the jail administrator's responsibility to make sure the admission packet is received and properly filled out and returned to the state mental hospital?

A. Actually, in Lafayette County the chancery clerk faxes all of that so the jail doesn't have to do it.

Q. Okay.

A. I mean, if they don't have it we send it with the patient, but in general the chancery clerk faxes it.

Q. Section 6, Medical Services Medical Procedures --

A. Hold on. Section 6, I'm on it.

Q. All right. Under 2.0 Medical -- well, I'm



going to do this for the record so we'll all know what we're looking at since these aren't numbered. Titled Medical Services, subject Medical Procedure Section 2.0, says receiving medical screening shall be performed on every inmate admitted to the detention facility. Do you see that?

A. I do.

Q. Was a medical screen performed on Princess Anderson?

A. Yes, it was performed.

Q. Can you show me a copy of it?

A. It's the form that you had with regards to the --

Q. The one that said suicide?

A. Psychiatric suicide, that's right. That's a medical screening. Here is one portion of it, I believe that's a medical screening. And then there is -- most of it -- and that actually is the -- this is part of it. That's the suicide screening and then medical health -- there it is right there.

Q. Okay. If you would, turn to Section 8, which is titled Food Services. It's about three or four pages past, titled Food Services, subject Food Preparation.

A. Okay.



Q. Turn to Page Section 2.10. An inmate may refuse a meal; however, this fact will be noted in the jailer's log. Do you see that?

A. I do.

Q. Is that the same of Lafayette County, that if a prisoner refuses to eat a meal that you note it in the log?

A. No.

Q. Did you see any notations in the log where Princess Anderson refused to eat any meals?

A. Yes. There is a reference -- and I'll have --

Q. I'm not talking about the log now. We've got it right here. If there is, let's take a look at it.

A. All right.

Q. I'm not trying to be a trick question because I don't remember seeing anything about --

A. No. I remember about her refusing -- in this statement, I believe it's going to be in this statement of the jailer's. I'm not certain. There actually was something about -- let me keep looking here. I do not see any note of her refusing to eat.

Q. Do you see any note when you look through the log book there, since we're on it and since you

just looked through it, did you see any notes indicating that Princess Anderson was communicative with the staff at any point?

A. In that booking log just then?

Q. In the booking log.

A. I don't recall. I recall references to Princess Anderson. I don't recall what they all were. And communicative, I don't -- I recall much in the statement of the jailers, but I don't recall anything specifically in the booking log about whether she was communicative or not.

Q. And the booking log's kept contemporaneous with the events that occur or should be kept contemporaneous?

A. Well, I misspoke. The booking log typically refers to people who are booked into the jail and people who are booked out actually. There would be a log of jail activity --

Q. What are you looking at?

A. This is called jailer's -- no, not in the booking log.

Q. But that's what you've been looking through to answer my questions is jailer's log?

A. Yes. But the booking log is something different. It's a log of people who are booked into



the jail.

Q. Just so the record is clear, we called -- I called it a booking log, but you were actually looking through the jailer's log?

A. That is correct. It is a report of activity that occurred, yes.

Q. So it's kept contemporaneous with when the activity occurs?

A. Yes. But, obviously, as you'll note on here, it's more -- it is -- it doesn't have nearly all the activity that occurs at a jail. It has some notations such as beginning and end of feeding time and when people left and when they came back.

Q. Well, under the policies and procedures, should there be a notation in the jail log when the jailers check on a mental patient who is at suicide risk such as Princess Anderson?

A. I believe that -- I believe that the policy calls for frequent monitoring, and I did in there -- I believe that they did do that, and I believe -- sometimes they notated things in the log and sometimes they didn't.

Q. Right. My question, though, is do the policies and procedures require them to note when they check on a mental patient who is at suicide



risk. That is my question.

A. Let's find that specific language. If you can point it out to me, the specific one about that one.

Q. Let me see. Look at title Administration Operations subject Suicide, which is towards -- go back Section 11.

A. So towards the back?

Q. Towards the back, yeah. Section 2.5.

A. It says when the inmate is released from the hospital and returned to the facility, inmates will be placed in isolation cell for observation. The inmate shall be visually checked every 15 minutes and the tech code bar shall be scanned with a digital scanner. But it doesn't say anything about making a notation in the jailer's log.

Q. I never heard, what's a tech code bar? I'm not familiar with that.

A. I do not know.

Q. Do you guys have it there in Lafayette County?

A. No.

Q. Were you provided any records with regard to scanners and tech code bars in this case?

A. No.



Q. All right. Let me look at Exhibit 9 for a moment.

MR. CZAMANSKE: Let's go off the record a second.

(Pause in proceedings)

Q. Section 3, title Separation, subject Mentally Disordered/Disoriented Inmates.

A. Back in the policies and procedures?

Q. Yeah, I'm sorry, back in the policies and procedures.

A. Which section?

Q. Section 3, title Separation. It's the one where it talked about the jailers not to diagnose mental illnesses.

A. Okay. I just passed it. Sorry. Separation mentally -- yes, I have it.

Q. 2.2, when an inmate exhibits one or more of the above behaviors, the jailer shall place the inmate in a separate confined area, parenthesis, isolation cell, closed parenthesis. Do you see that?

A. I do.

Q. The cell in which the inmate is placed shall be located where increased observation by the jailer is possible. Do you see that?

A. I do.

Q. All right. Have you been to the actual jail?

A. I have not.

Q. Do you know whether or not the cell in which Princess Anderson was placed whether or not it was located where increased observation would be possible? Do you know one way or the other?

A. I do not know.

Q. You see that a security log, parenthesis, Appendix G, will be started as soon as the inmate is placed in the isolation cell. Do you see that?

A. Yes. And where it says C tank A11 and A12, yes, I see that.

Q. Do you know what C tank A11 A12 means?

A. My guess is that this is an isolation, specific suicide watch cell in the booking area, not in the -- so in other words, there is a specific isolation cell that's designated that where maybe three of them, C tank and cell number A11 and A12, are specifically used for isolation. So in other words, when they have a suicide watch or if a person that they determine needs increased observation, they often used these cells I guess.

Q. Well, it says when an inmate exhibits one or more of the above behaviors. Do you see that?



That's how it starts out, 2.2?

A. Yes, I do see that.

Q. Those are the behaviors you and I went through before that we agreed Princess Anderson exhibited while she was in jail and even before she got to the jail?

A. Right. She was there specifically for those reasons.

Q. Right. And she was put in a cell by herself, right?

A. That is correct, or that's my understanding.

Q. What I guess my question is, you read these, should a security log have been started for Princess Anderson?

A. Well, she was not in the jail and developed mental problems. She was held there specifically for mental illness and was awaiting a Writ process. So she should not have been held with other inmates and she wasn't. But as far as this is for when people -- when they're observing someone that's showing signs of mental illness to determine, you know, do they maybe -- do they have a mental illness. But in her case, we know that she does because, I mean, that's -- from her records we know that that's precisely why



she was sent there.

Q. But shouldn't a security log have been started with her under 2.2?

A. If this applied to her. But this is talking about inmates that they're observing with apparent mental problems, inmates with apparent mental problems. She wasn't an inmate with an apparent mental problem. She was a detainee specifically there for psychiatric illness.

Q. So you're saying she's not an inmate under the policies and procedures of Marshall County?

A. No, I'm not saying that.

Q. I'm probably making this more difficult than I intended. I'm just wanting to know if you're going to testify in trial that this section with regard to security log, that a security log should or should not have been started on Princess Anderson. That's all I want to know.

A. I believe that she was -- what I believe is that she was placed in a cell by herself, and that they did not implement this policy. In other words, they did not observe behavior that they felt justified removing a patient from where they were and moving them to a specific isolation cell. So this policy and procedure is written for you have an



inmate who's in general population who's exhibiting signs of a mental illness and they're moving out from general population and moving them into an isolation cell and starting a security log. And that isn't the situation with Princess Anderson. She was brought to the jail with a known psychiatric illness and was placed in a solitary cell where she couldn't injure other people or, you know, where she could be under close observation, but it's not necessarily under this policy and procedure.

Q. So the shorter answer is, no security log needed under the policies and procedures for Princess Anderson in your opinion?

A. There -- it is -- I'm not aware of a security log being started.

Q. I understand that. But I want to make sure I understand your opinion and I'm trying to get -- you've explained it. I've heard you explain it, but I haven't actually heard you answer it. Is it true that your opinion is there's no security log required under the policies and procedures for Princess Anderson when she is detained there at Marshall County according to their own policies and procedures?

A. I believe that the procedures that -- I

believe that the procedure you showed us a minute ago, which required frequent observation, 15 minute observation, and placing in a cell by themselves does apply, but this procedure is not -- this is not -- is not designed for psychiatric holding patients, no. That procedure was not written for those patients.

Q. It doesn't apply to Princess Anderson?

A. Okay.

Q. Is that what you're saying? I understand your explanation, but I'm trying to get to the -- usually we ask that people answer yes or no and then explain. I get the explanation, but I don't get the yes or no. And I'm not trying to pick on you, but I want to make sure we're clear, you don't believe this policy applies to Princess Anderson?

A. I can't give you a yes or no. Let me read the whole policy.

Q. All right. So we're clear, the section I was referencing was 2.2. under title Separation subject Mentally Disordered/Disoriented Inmates.

A. I believe that in general this policy applies to Princess Anderson; however, I don't believe that she was put in an isolation cell C tank A11 or A12. And, therefore, since she was not put in one of those three cells I don't believe a security



log was necessary in this case.

Q. Okay. Thank you. What was Princess Anderson's condition on February 11th when she was transferred from the jail to Alliance Healthcare?

A. She was suffering from four conditions: Acute delirium, pregnancy, dehydration and hypernatremia. Those are -- hypernatremia is -- goes along the dehydration, and Rhabdomyolysis.

Q. Not to quibble with your math, but that's five I count.

A. No, that's -- I'm sorry. Dehydration and hypernatremia is from the same --

Q. Oh, the same. You're combining --

A. Those are the same. They're one in the same. Hypernatremia is a characteristic of people who are significantly dehydrated.

Q. Okay. It was my understanding -- I've attended the depositions that at the time Princess Anderson's mother came in on February 11th to check on her daughter, that she was found naked on the ground in her on excrement. Is that your understanding?

A. It is my understanding that she was -- no, well, what my understanding was is that she was unable to stand on her own and an ambulance was



summoned. And her mother -- it was also my understanding that her mother came not to check on her, but to take her to the hospital that morning for treatment of her pregnancy. And it was my understanding that she was lying down and potentially on the floor, and I don't know about the state of undress at that particular time. There were other times when she was described as not being clothed. But I know that she was lying down unable to stand up and an ambulance was called, yes.

Q. My question is, do you know how long she had been in that condition where she was lying down and unable to stand up?

A. I know that there --

MR. O'DONNELL: Object to the form of the question. Go ahead.

A. I know that there were reports -- there were reports at least from the evening before that she was standing up, the day before. That's -- and the record doesn't -- to the best of my knowledge the record doesn't reflect anything about the night or the morning of the 11th.

Q. When you say reports, are you talking about deposition testimony?

A. Well, there are statements. There are



logs. There's statements. And then also Dr. Mangle's statement in his admission H and P where he said, was found down after being seen up ambulatory the day before, he said. Something that he wrote on that date.

Q. You said log statements and Dr. Mangle's history. Let's take those one at a time. Is there anything in the logs about the last time Princess Anderson was able to stand on her own prior to being found on February 11th?

A. Some of the difficulty I'm having with my memory is that I read the statements of the jailers and the booking log all at the same time. Those are getting confused in my mind.

Q. In fairness, the booking logs were done in February, right? We can say booking logs. The logs that you're looking at were done in February?

A. Yes. And the statements were done in April, or at least that statement was done in April. There may be a couple more. But, also, in fairness, the booking logs do not list all that went on with Princess Anderson. I haven't seen anything in the booking log as to that whether she was standing or lying. I don't know any reference to her position in the day prior, no.

Q. Let's take a look at the written statement of Ardella Anderson. She does her by days. See at the top where they're dated?

A. That's right.

Q. So according to Ardella Anderson's statement, when is the last time she saw Princess Anderson up and about before the morning of?

A. 1:15 p.m. on February 10th.

Q. And with regard to Ardella Anderson's notes about the day, the month, which would February 11th.

A. Mom came on a couple of days.

Q. Well, I'm talking about the last time that they found her, February 11th.

A. Okay.

Q. What time does Ardella Anderson indicate that Mom came?

A. 12:37 p.m.

Q. Is there any indication by Ardella Anderson or a statement that she ever observed Princess Anderson -- strike that. Is there any indication that Princess Anderson was able to get up off the floor at all up until the time they transported her by way of ambulance?

A. You mean on the day of the 11th?

Q. On the day of the 11th.



A. No.

Q. And according to the statement, and I assume it would be backed by the logs, what time was that that they took her out to the hospital?

A. She left at 12:50 p.m. And the ambulance was called at 12:40 p.m., and I think they arrived and transported her before one o'clock.

Q. So we've looked at the jail logs. We've looked at least one of the statements, and there's other statements there. Here's my question. We know if we're to believe Ardella Anderson's statement that she saw Princess Anderson up and about at 1:15 p.m. on February 10th, right?

A. That is correct.

Q. And is there any indication in the records anywhere, now I'm excluding deposition testimony, that anybody saw Princess Anderson up off the floor at any time after 1:15 p.m. on February 10th?

A. I'm not aware of it.

Q. With regard to the conditions, the acute delirium, I think you've already testified that's a condition that Ms. Anderson came to the jail with?

A. That's right.

Q. Pregnancy, that would be another condition she came into the jail with?



A. That's correct.

Q. Dehydration and hypernatremia, let's talk about that for a second.

A. Okay.

Q. How do you determine whether somebody is dehydrated? What do you look for as an ER doctor?

A. Well, there are clinical appearances, but in addition to that the most reliable are actually laboratory tests such as the urinalysis, such as electrolytes in the blood. Then that's it, in fact, is -- I mean, that's what made the diagnosis in this case.

Q. All right.

A. Hypernatremia.

Q. Well, the hypernatremia, wouldn't that indicate the amount of I guess sodium in the blood?

A. It indicates the relative lack of water. There's no extra sodium. There's lack of water making the sodium to be high.

Q. More concentrated?

A. Exactly. More concentrated blood, more concentrated urine.

Q. Now at the time of Princess Anderson's discharge from Baptist DeSoto prior to going to the jail we know that her urine was concentrated --



A. Yes.

Q. -- greater than whatever their range was?

A. Correct.

Q. We don't know what her blood concentration was because there was no blood test done?

A. Correct.

Q. If you were to just go on the urinalysis, there's a pretty good chance she was dehydrated when she went to jail, wasn't there?

MR. DAVIS: Object to form.

A. Well, there's good evidence that she wasn't taking fluids even at Baptist DeSoto. So in other words, she was in the early stages of -- you can presume that she was at Baptist DeSoto for -- I mean, not presume, she was at Baptist DeSoto for 18 hours. No evidence that she took any oral fluid during that time. So she was in the early stages of dehydration, yes.

Q. All right. So as far as whether or not she had hypernatremia, we wouldn't be able to tell at that time, at the time of her discharge from Baptist DeSoto, we wouldn't be able to tell because there was no blood test?

A. Correct.

Q. The Rhabdo, now that would be a condition

that you testified you don't believe she had at Baptist DeSoto because there's no blood on the dip test?

A. Well, the Rhabdo had one of two -- I believe the Rhabdo had one of two cause --

Q. Let me try this. Do you have an opinion as to whether or not Princess Anderson had Rhabdo when she was discharged from Baptist DeSoto and sent to jail?

MR. DAVIS: Object to form.

A. I have an opinion about what caused her Rhabdomyolysis, and it is of two things. One of them is directly related to the drug ingestion, the purple drink. And if so, it was probably in the early stages -- it was in the early stages and was caused due to that amount. I don't think any person is going to know for certain whether the Rhabdomyolysis was as a direct result of her drug ingestion, which is very likely, and was therefore starting at Baptist DeSoto, so the answer could be. Or she could have remained immobile for most of the night of the 10th and the 11th and developed Rhabdomyolysis on the basis of immobility. And I can't determine which of those two it was. So I don't -- the short answer is I don't know whether she had Rhabdo when she left



Baptist DeSoto.

Q. All right. She had it when she was taken to -- when Dr. Mangle saw her?

A. Yes. She had it when she first arrived at Alliance Healthcare.

Q. Okay. That's right. Alliance Healthcare. And then she went from Alliance healthcare to I think we've been calling it Baptist Union?

Q. Baptist Union County or Baptist New Albany. It's referred as both. But Baptist Union?

Q. When was the last time you took care -- that you had a patient admitted to the hospital -- well, strike that. Rhabdo, hypernatremia, there's no doubt those are emergency medical situations?

A. Yes.

Q. Dehydration can be -- can certainly be an emergency medical situation?

A. Yes.

Q. When was the last time that you -- strike that. Do you have admitting privileges at any of the hospitals?

A. No.

Q. When was the last time you had admission privileges at a hospital?

A. Emergency physicians don't have admitting



privileges. Never had admitting privileges.

Q. All right. Is hypernatremia typically treated by admitting somebody to the hospital and treatment going on?

A. Yes.

Q. Have you ever been a physician who's involved in the actual treatment of hypernatremia?

A. Multiple times. Regularly.

Q. So that's something you could also treat in the ER?

A. Yes.

Q. Is that somebody that you would treat -- initially treat in the ER and then admit that person to the hospital, or can you treat it and discharge somebody in the ER?

A. You can sometimes treat them in the emergency department. Often people with hypernatremia are admitted to the hospital, but not always.

Q. Have you ever had anybody come in with hypernatremia that you treated and released and you didn't admit to the hospital?

A. Yes.

Q. What about Rhabdomyolysis -- I know I'm pronouncing it wrong --



A. Rhabdomyolysis.

Q. Is that something that can be treated in the ER and without an admission?

A. There are cases -- most of them get admitted, but there are cases when they're treated and discharged.

MR. DAVIS: Just to be clear, since we're back to ER, just want to make sure my standing objection is still in place.

MR. CZAMANSKE: Okay. Yeah.

Q. Have you ever treated a person for Rhabdomyolysis and discharged them from the ER?

A. Well, that's a difficult question because I see people daily -- or not daily -- weekly that I believe may have Rhabdomyolysis, and I either do the test or send them to the emergency room and give IV fluids. Sometimes people have a very mild case and they get discharged. But in general if it were anything near this serious, they would ultimately be admitted to the hospital, but I regularly treat people in my practice at the jail and at my clinic who I either suspect or, you know, know. So in other words, I have people that come to my clinic regularly with dark urine, with the clinical signs of Rhabdomyolysis. I might start IV fluids and, you

know, get tests and then ultimately say, no, it's not a serious case, they -- no, it is a serious case, they need to go to the hospital. I'm having a little difficulty with your --

Q. Let me be more specific. A case like Princess Anderson's presents with when she leaves the jail and goes to get medical care, after the jail, that situation, she can't get up off the ground, whatever your understanding is as to her physical condition, that kind of situation, is that something that you would defer to a -- I don't know who treats it, internal medicine doctor, or somebody like that, that has privileges at a hospital and treats that kind of thing?

MR. O'DONNELL: Object to form. Vague.

A. Well, emergency physicians don't admit people to the hospital. So everybody gets admitted to a hospital is -- short answer is yes. When I'm in a scenario when a person would have that severe a thing, they would be admitted to the hospital. It would not be me that was caring for them beyond the initial time in the emergency department. Now sometimes remain in the emergency department or in my care for 24 hours or something. So, you know, I



would treat them for the first 24 or 48 hours, however long they remained in my care. But, ultimately, they would be admitted to the hospital.

Q. What type of specialty would treat that kind of thing in the hospital?

A. Typically internal medicine doctor or family practice who's working these days as a hospitalist. Most places have hospitalists. Such as Dr. Mangle was a hospitalist. I don't know whether he's board certified in internal medicine or family medicine, but he's a hospitalist. He is admitting patients from the emergency department and taking care of them with a medical problem as opposed to a surgical.

Q. Okay. And my understanding of reading your opinions that you're critical of Dr. Mangle's care of this patient. Is that a fair way to put it?

A. That is correct.

Q. Do you believe that he violated the standard of care with regard to his treatment of this patient?

A. That is correct.

Q. And I'd like to know all the ways in which you believe he violated the standard of care.

A. Well, there are two main -- my two main



problems, or my two main ways that I believe he violated the standard of care, one of them in regard to the hypernatremia in which it was essentially never -- it was never corrected during the four days that she was at the hospital. So she was -- she was severely dehydrated and she did not receive enough fluids, specifically enough free water, to correct her hypernatremia. And that ultimately resulted after -- so even four days, 96 hours after she had been in the hospital, she still had symptoms of the same sodium level that she had to begin with, and that resulted in seizures and ultimately is what led to her demise.

Q. That's one way, not getting enough fluids for the hypernatremia, if I can kind of condense it?

A. That's right.

Q. What's the second one?

A. It took almost 24 hours after she presented to a hospital for him to even consider Rhabdomyolysis and it was another six hours till he actually said that that's what she had.

Q. Are you critical of the treatment of the Rhabdo?

A. It was not -- yes, it not aggressive, although -- although, later people said that the



reason that he didn't -- the usual treatment would be give sodium bicarbonate in IV fluids to try to -- to make the urine have a higher pH and get rid of myoglobin and limit the damage to the kidneys. And the reason that it was said by later caregivers that he didn't do that was because she already had a high sodium and he didn't want to give her more sodium bicarbonate. There's some rationale that can be made to that, although she certainly did not -- the other treatment of Rhabdomyolysis is aggressive fluid and getting aggressive amounts of fluid without the sodium bicarbonate. She didn't receive that either so it was inadequate treatment.

Q. All right. With regard to -- let's go to the hypernatremia.

A. Okay.

Q. You said that he did not give enough fluids?

A. Yes, sir.

Q. And I know there's a calculation that y'all do and I saw it in your notes.

A. That's right.

Q. Explain to me the calculation of how you figure how much fluids to give somebody.

A. Okay. There are two different things that

are discussed in general. One of them is the amount of fluids that somebody requires on an ongoing basis. So in other words, just a hospitalized patient who's not taking fluids by mouth, there's a way to calculate what is called your maintenance fluid requirements. And her maintenance fluid requirements -- so in other words, to replace the ongoing urine that she was making, the ongoing sweating -- and that's higher in a hospitalized patient than in other people -- but her ongoing fluid requirements were about 3200 cc's per --

Q. What's the --

A. Holliday-Segar formula.

Q. Tell me in layman's terms, if I was going to calculate it how I would do it. If I take a person's weight times --

A. That's right. You give so much for the first ten kilograms, so much for the second kilogram because it's based on their weight.

Q. Right.

A. And so hers comes out to 137 cc's an hour, or using the Holliday-Segar formula that comes out to around 3200 cc's per day as her maintenance fluid requirement. So that's not the correcting water deficits, but only for ongoing losses.



Q. And then how much to correct?

A. To correct the hypernatremia she needs free water. And the amount of free water deficit that she had was 8.2 liters. I actually put in my report 10. That was an error on my part and I used -- I used presuming she was a male, not a female. Using the female correction is 8.2 liters of free water that she had lost. In other words, she was -- she had a water deficit or a free water deficit of 8.2 liters. And how much fluids she needs depends on how concentrated -- in other words, we don't inject just plain water. If you injected just plain water it would be 8.2 liters, but because there's some sodium in -- so half normal saline you should require essentially 16 liters, or twice as much fluid as the free water deficit. She had a free water deficit of 8.2 liters.

Q. So how many cc's per hour whatever do you have to give her for that?

A. You have to correct that 8.2 liters over the -- and you either can correct it quickly or slowly depending on how quickly the hypernatremia develops.

Q. If we're going to do it slowly, I know we've got 137 cc's per hour just to maintain. How



many more cc's per hour to correct slowly?

A. You're going to correct it over two days, and typically you're going to give some boluses. So it needs to be in total over a couple -- the two days. You can say essentially 10 liters of fluid, but over a couple of days. I don't have the -- typically you wouldn't give that over -- in an hour. You would have given boluses of -- it's 10 liters.

Q. What would be the steady rate and then tell me how many boluses and at what amount? I'm just trying to figure this out.

A. It doesn't work like that.

Q. Tell me how much it would be.

A. She needed approximately 10 liters of fluid over the first couple of days that she was there.

Q. At what rate, though? That's what I'm asking. At what rate would she get --

A. Take 10 liters and divide it by 48 and it will tell you. Anybody got a calculator?

Q. No, that's all right.

A. But that's not how you do it, though. You give two liters all at once and then you give the balance over the remaining 48. Do you understand what I'm -- I'm sorry. I -- you typically would give a bolus of a couple of liters -- in other words,



right away she would have received a couple of bags. Then you would give it at 200/225 an hour till you can correct -- and you keep measuring your sodium to make sure it's coming down. You keep on till her sodium gets normal.

Q. Does the renal production or the renal capacity affect how much you give a person?

A. Certainly if they're in renal failure you're going to ultimately have to dialyze them. So it does affect it; however, in this case what she needed was more fluid to flush her kidneys in other words.

Q. Did she have renal failure, though, I guess is the question?

A. She had some degree of renal failure but not enough to stop urine production. And, in fact, it would have been improved by more fluids. There was some degree of renal failure as just her dehydration, not a lack of production of urine due to lack of blood. In other words, lack of -- being so dehydrated. That causes the creatine to be elevated itself.

Q. Don't these conditions, both Rhabdo and hypernatremia, affect the organs including the kidneys?

A. Absolutely.
Q. And one of the things a physician has to consider who's treating this as an inpatient in the hospital is that person's renal failure and how much fluids they're -- assuming they don't have dialysis, do you know whether or not Baptist Union had the capacity to do dialysis?
A. First of all -- I do not know that, but she didn't even come anywhere close to needing dialysis. Her renal failure was not nearly of a level to indicate the need for dialysis. It indicated the need for fluids, not dialysis.
Q. And it could have -- there may have been a need for dialysis if she had received the increased fluid, correct?
A. It is possible to -- it is possible she could have gone on to more renal failure that she had, but she never did. I mean, it is possible that her kidneys could have -- that the Rhabdomyolysis could have worsened her kidney function to where she needed dialysis, but it did not ever go to that point.
Q. And when you talked about the sodium, the sodium did not drop while she was at Baptist Union. I think that's what you said, right?



A. That's right. Essentially not. I mean, it went -- the numbers, believe I put them in my report, are like 161, 158, 159, 167. It was all within -- those are all essentially the same number.
Q. Did those numbers drop when she was transferred to Baptist DeSoto?
A. Yes, within a day or two.
Q. They did --
A. They ultimately corrected them, yes.
Q. The Rhabdo is measured by the creatine; is that right? Or is that the myoglobin? Well, both of them, isn't it?
A. Rhabdo is the -- Rhabdomyolysis is the breakdown of muscle and what -- a protein in your muscle called myoglobin spills out into your blood, travels around and is filtered out by your kidneys, and because it -- you can think of it it's like mud. I mean, it clogs up your kidneys causing kidney failure. That's the main problem that Rhabdomyolysis and the myoglobin causes, it stops up your kidneys.
Q. How long does it take the Rhabdo to start clogging up the kidneys?
A. Within 12 to 24 hours of -- you know, of a certain -- obviously, that's to get to a certain threshold.



Q. Right.
A. There's a threshold below which your kidneys can clear it, but then once you cross that threshold then it's going to start damaging the kidneys pretty quickly.
Q. Are you going to express an opinion as to when that threshold occurred in Princess Anderson's case?
A. No. But the threshold had been crossed by the time she presented to Alliance Healthcare. I mean, she was in significant Rhabdo and needed significant treatment to try to correct that.
Q. I mean -- strike that. Did Princess Anderson receive Lasix while she was at Baptist Union?
A. I know that he discussed that. I believe that he, in fact, did use some Lasix.
Q. And what's the purpose of Lasix then?
A. Is to try to increase the urine flow through the kidneys to try to essentially flush the kidneys to flush that myoglobin out.
Q. It's to try and get rid of fluid, isn't it?
A. Well, in the case of -- in her case she was already significantly dehydrated, so giving her Lasix would make her dehydration worse unless you had given



lots and lots of fluid. That would be the treatment is to give plenty of fluids first to see if on your -- just with fluids you could correct the dehydration, you could flush the kidneys. And if that wasn't working, you could potentially give Lasix to try to stimulate the kidneys further. I believe that he did give Lasix but without the first part of giving enough fluids to -- the first step was to get fluids and see if you could get her kidneys working on that basis.
Q. But there is a risk to the patient if you overload them with fluid, is there not? If you give them -- in other words -- let me strike that. Let me ask it a different way. Can you give a patient too much fluid?
A. Absolutely you can.
Q. And that can be harmful to the patient?
A. It could be. Any patient can be overloaded. However, in this case he never even got to the enough. So in other words, he was a long way from fluid overloading her.
Q. These documents are research it looks like on different things, a lot of it seems to have to do with cough syrups, maybe some bath salts, addiction -- Rhabdo.

A. Those articles are about the three most likely causes of her acute delirium that she had at Baptist DeSoto.

MR. CZAMANSKE: Let's take a break here.

(Short recess).

(Exhibit No. 10 was marked.)

Q. I'm going to sort around here because I've got some notes here, so bear with me and get whatever you need to get.

A. You just had -- I just want to say, you had -- this last thing you were going to make an exhibit, like my reference documents, those two are part of those reference documents if you want to include that. That's part of the reference.

Q. Thank you. I marked at the break as Exhibit 10, deposition exhibit for lack of a better word, the research that you did?

A. That's fine.

Q. And it's multiple articles. It's not just one. It's multiple articles. Base on your testimony and based on what I've heard you say, is it your opinion that the Rhabdomyolysis is what ultimately caused Princess Anderson's death?

A. She had multisystem organ failure, but, no,



it was the hypernatremia that most directly related -- resulted in her death. The hypernatremia caused seizures and metabolic encephalopathy. The Rhabdomyolysis essentially corrected or -- typically if you don't require dialysis -- you know, even if you require dialysis, but in this case she didn't require dialysis, and it actually corrected on its own. So technically, one of her causes of death would be multisystem organ failure, including acute -- you'll see the term acute tubular necrosis and Rhabdomyolysis, but in fact that was getting better and would not have killed her but for the encephalopathy.

Q. Caused by the dehydration and hypernatremia?

A. Prolonged hypernatremia, that's correct.

Q. How long does hypernatremia have to go on to be prolonged the way you defined prolonged?

A. I don't believe there is a definition, but four days is long.

Q. Four days?

A. Four days is prolonged. It's how long it went on this case and that is prolonged. I don't know there is a definition of how long prolonged is.

Q. Let's talk about symptoms for a minute, get



away from the test, just the symptoms. Symptoms for Rhabdomyolysis, or we've been calling it Rhabdo, symptoms for Rhabdo, what would you expect?

A. Weakness, specifically muscle weakness, inability to stand on your own, muscle aches and pains, dark-colored urine. That's the primary ones.

Q. Symptoms you expect to see in hypernatremia?

A. And that's dehydration, as well. Hypernatremia and dehydration together.

Q. Right.

A. Weakness, confusion, altered mental status. That's the primary ones.

Q. Okay. If Rhabdo is caused by immobility, because I understand it could be caused by other things, but if it's caused by immobility, how long does the person have to be immobile before the Rhabdo starts -- before you start having a breakdown?

A. I know you're referring to Dr. Sobel having said it had to be -- at least I read a reference in his report that it had to be a prolonged time, but I will just tell you this, the short answer is, several hours, perhaps eight to 12 hours of immobility. And the demonstration of that is that people get Rhabdo after they get intoxicated and pass out. So the



length of time you're intoxicated and pass out, or, you know, in the course of a prolonged operation. So eight to 12 hours is in the ballpark, overnight.

Q. Okay. If an inmate at your facility where you work at Lafayette County were to display signs of a seizure, all right, you know what I'm talking about?

A. Uh-huh (Indicating yes).

Q. Would you expect that the county, the jailers, would contact you? Would you expect them to contact you to examine that person or at least -- if not you, call an ambulance?

A. The short answer is yes. If someone were exhibiting signs of a seizure, I would expect them to. Now there are -- all the time jailers see signs that they don't know if it's a seizure and they may ask me the next day this person -- so, not necessarily me, but in general if a person were having a seizure -- and for the record I see no evidence that she had a seizure at the jail. There's no evidence of that, so a description of a lay -- lay people can't describe seizures very well. So if a medically trained person said a person was having a seizure, they would need to call an ambulance. But people in jail exhibit behaviors that lay people may

describe as a seizure, which is not in fact at all a seizure, and I wouldn't expect to take any action based on that. But if a medically trained person identifies a seizure, then of course, they need to go to the hospital.

Q. What are the symptoms you would expect to see for a seizure?

A. The person would need to be unconscious. So they would need to be unconscious. They would need to have jerking of their limbs. And there's usually -- it's usually followed by postictal so it stops. In other words, the jerking stops and followed by a postictal state where they're confused and stuff. Nothing in any description I've read says anything about -- in any statement, any testimony, said anything about Princess Anderson having anything that resembled a seizure at the jail. I haven't seen anything --

Q. Yeah. I wasn't asking if you had read anything about it. I was just wondering if that was the type serious medical condition that you would expect the facility to contact an ambulance or equivalent of?

A. Yes. And that is -- specifically the answer is yes. That is a change, a significant



change in her condition. That's right.

Q. All right. The documents for the -- Communicare filled out the report, the pre-evaluation screen I think we called it?

A. Yes.

Q. I'm trying to make sure I understand how this works. The Communicare fills it out. We know that under the policies and procedures the jail administrator is to make sure that document, when they transfer the person, goes to the state mental hospital?

A. Only after the hearing has occurred, so three days way down the road.

Q. Where does the report go between the hearing and --

A. Typically the Communicare worker gives it to the physicians so that they have it when they conduct their mental and medical examination of the patient. So the Communicare worker deals with it internally and gives it to the physician. It's done differently in Marshall County than it is here. Here we actually do the physician's examinations in the jail, and I believe in Marshall County I believe their policy was to transport the person to the Communicare office. So I would presume that the



Communicare worker took it back to her office for the physicians to review the next day.

Q. Do you know what physicians would have been reviewing that?

A. Whichever psychiatrists were on duty at Communicare that next day, but I do not know.

Q. With regard to the reports, I think -- I don't know if it was in Baptist Union's, there's a report somewhere in the record of bruising on the legs. Do you recall seeing that?

A. Yes.

Q. Is that a symptom you'd associate with either hypernatremia or Rhabdo, or can it be associated with that?

A. Yes, it can be associated with Rhabdo. More specifically, you get -- when you get Rhabdo and hypernatremia, there is the concern about poor clotting. In other words, easy bruise-ability with both of those conditions. You would expect bruising with both of those conditions.

Q. One last question, do you believe there are any policies and procedures that -- because when I asked you about whether or not there were any violated, I think your phrase both in your report and to me was, they were substantially complied with.



But were there some, in fact -- that's kind of a qualifying answer. Were there some that were in fact violated?

A. Not that I'm aware of.

Q. Okay. That's all I have.

MR. O'DONNELL: Walt, you want to just recess at this point?

MR. DAVIS: With the understanding we're going to reconvene. Nothing right now.

(Off record discussion).

MR. CZAMANSKE: I thought I had marked these, can I mark his notes as Exhibit 11.

(Exhibit No. 11 was marked.)

(Deposition recessed at 12:20 p.m.)

C E R T I F I C A T E

STATE OF MISSISSIPPI )

COUNTY OF LEE )

RE: DEPOSITION OF THOMAS FOWLKES, M.D.

I, LuAnne Funderburk, CCR 1046, a Notary Public within and for the aforesaid county and state, duly commissioned and acting, hereby certify that the foregoing proceedings were taken before me at the time and place set forth above; that the statements were written by me in machine shorthand; that the statements were thereafter transcribed by me, or under my direct supervision, by means of computer-aided transcription, constituting a true and correct transcription of the proceedings; and that the witness was by me duly sworn to testify to the truth and nothing but the truth in this cause.

I further certify that I am not a relative or employee of any of the parties, or of counsel, nor am I financially or otherwise interested in the outcome of this action.

Witness my hand and seal on this 31st day of January, 2014.

My Commission Expires: CCR 1046
February 28, 2015 Notary Public



UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF MISSISSIPPI
WESTERN DIVISION

ANGELA ANDERSON, Personally, and on behalf of the WRONGFUL DEATH BENEFICIARIES of PRINCESS ANDERSON, Deceased PLAINTIFF

VS. NO. 3:12-CV-92-MPM-SAA

MARSHALL COUNTY, MISSISSIPPI and BAPTIST MEMORIAL HOSPITAL-DESOTO DEFENDANTS

CERTIFICATE

I, Thomas Fowlkes, M.D., have read the foregoing pages, 1-132, of the transcript of my deposition given on January 9, 2014, and it is true, correct and complete to the best of my knowledge, recollection and belief except for the list of corrections, if any, attached on a separate sheet herewith. Witness my hand, this the _____ day of _____, 2014.

_____
Thomas Fowlkes

CERTIFICATE

Subscribed and sworn to before me, this the _____ day of _____, 2014.

_____
Notary Public in and for the
County of _____
My Commission State of Mississippi



ADVANCED COURT REPORTING
P.O. BOX 761
TUPELO, MISSISSIPPI 38802-0761

CORRECTION LIST

Angela Anderson, et al
vs.
Marshall County, Mississippi, et al

Federal - Western - No. 3:12-CV-92-MPM-SAA

CAPTION

January 9, 2014 Thomas Fowlkes, M.D.
DATE OF DEPOSITION DEPONENT'S NAME

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Thomas Fowlkes, M.D.